DOCUMENT RESUME

ED 149 555 EC 103 872

TITLE Primary Prevention: An Idea Whose Time Has Come.
INSTITUTION National Inst. of Mental Health (DHEW), Rockville, Md.
REPORT NO (ADM)77-447
PUB DATE 77
NOTE 205p.; Proceedings of the pilot conference on Primary Prevention (April 2-4, 1976)
AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (Stock No. 017-024-0063501)

EDRS PRICE MF-$0.83 HC-$11.37 Plus Postage.
DESCRIPTORS Agencies; *Conference Reports; Conferences; *Emotionally Disturbed; *Mental Illness; *Prevention; Workshops

ABSTRACT

Presented are three formal papers and 11 workshop summary statements from a 1976 pilot conference on primary prevention of mental illness. Initial chapters describe the design and implementation of the conference and review results of a preconference survey on primary prevention programing. The three formal papers included are "An Overview of Primary Prevention Programing" (S. Goldston), "Basic Strategies in Designing Primary Prevention Programs" (W. Hollister), and "Evaluating Achievable Objectives for Primary Prevention" (B. Bloom). Workshop summary statements cover three areas: primary prevention for specific target groups (including newborn infants at high risk for emotional disorder, widowed persons, and preschoolers); agency strategies for primary prevention (including an epidemiological approach); and aspects of prevention (funding, community involvement, and program management). The final section provides information on conference work groups, conference evaluation, and conference recommendations. (CL)

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PRIMARY PREVENTION: AN IDEA WHOSE TIME HAS COME

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PROCEEDINGS OF THE PILOT CONFERENCE ON PRIMARY PREVENTION

April 2-4, 1976

Compiled and Edited by

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EC103972

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

This proceedings' document initiates the new Primary Prevention Publication Series. The purpose of this series is to disseminate and exchange information on primary prevention activities in the mental health field; stimulate the development of primary prevention projects in mental health, public health, and other human service facilities; encourage the training of mental health workers in aspects of primary prevention; and promote research on primary prevention issues. This series will include scientific monographs, conference proceedings, commissioned papers, and other materials, thereby meeting a need for information about primary prevention. Publications in this series will be issued as materials and manuscripts are developed. The views expressed in these publications are those of the author(s) and do not necessarily reflect the official position of the National Institute of Mental Health or the Department of Health, Education, and Welfare.

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DHEW Publication No. (ADM)77-447
Printed 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 (paper cover)

Stock No. 017-024-00535-1

FOREWORD

The lack of a sophisticated and comprehensive primary prevention program in mental health stands today as a major barrier between our present knowledge and resources and attainment of the goals this country has established for its mental health system. To be clear, a key goal of that system is the prevention of mental illness and the promotion of mental health.

Primary Prevention: An Idea Whose Time Has Come provides a timely and encouraging response to the assertion made above. First, these published proceedings of the Pilot Conference on Primary Prevention tangibly represent the commitment of the Federal Government and the constituencies of the national mental health effort to the task at hand. Further, this commitment is additionally strengthened by the fact that this volume marks the first of a new series of documents on primary prevention to be published by the National Institute of Mental Health (NIMH).

The volume and the program activity that has brought it about constitute a milepost in a 100-year saga of mental health as a public health endeavor. It was only within the last half of the 19th century that the discovery of germs as the causative agents of some diseases enabled the emergence of effective public health measures, based on a link between specific health hazards and responsive community action. And it was roughly within the same time frame that a national mental health movement began to gain the form and substance by which we know it today.

Intervening achievements have been numerous and notable. The turn of the century saw the lifework of a man named Clifford Beers evolving into a nationwide citizens' coalition against mental illness. The development of social psychiatry suggested a need and led, along one of its many paths, to the growth of the child guidance movement with its emphasis on preventive activities. A decade later, World War II prompted an increasing grass-roots awareness of the national toll of mental illness that resulted in legislative authorization of the NIMH, with a mandate to support and conduct programs in research, services development, and manpower education and training.

Since the Institute was established, a major portion of its activities have involved research, manpower training and education, and the development of service delivery systems that have focused on

the treatment and rehabilitation of mentally ill individuals. Pressing demands and accomplishments in these spheres may have tended to overshadow an equally impressive NIMH record of support of new knowledge and innovative approaches in the area of primary prevention.

One particular mechanism for the implementation of preventive efforts is found in the consultation and education (C & E) capability of community mental health centers. But as the authors note in the introduction to this volume, the potential of the C & E function, especially primary prevention programing, has never been realized.

The Pilot Conference, supported by contract funds made available by the NIMH, enabled the Mental Health Association (formerly the National Association for Mental Health) to construct a model for informing and educating key decisionmakers in community mental health centers about primary prevention. This volume, like the conference, addresses both the theoretical aspects and the working strategies of primary prevention. The usefulness of the book is enhanced by chapters that evaluate the conference which it reports and list recommendations resulting from the conference. I would hope that a wide distribution of the volume will extend the substantive value of the conference to mental health workers across the country who are seeking new and effective approaches to primary prevention programing. The document should serve as a valuable sourcebook for CMHC staffs and board members alike, for mental health trainers, and for concerned legislative and voting participants in the mental health system.

We intend that the proceedings of the Pilot Conference and subsequent additions to the new publication series represent a renewal on the part of the NIMH to primary prevention as well as significant contributions toward advancing this crucial aspect of community mental health endeavors.

Bertram S. Brown, M.D.
Director
National Institute of Mental Health

PREFACE

The concept of prevention as applied to any pathologic condition would ordinarily be free of controversy or challenge.* However, the mental health field has been notably inhibited in the development of an effective preventive component. This situation is in part a reaction to unsupported claims made by enthusiastic advocates of well-intended preventive efforts. Considerable skepticism has been evoked in response to programs described as being preventive because such efforts lacked reliable evaluation and were applied unsystematically to small random populations.

Another deterrent to primary prevention program development has been the limited background of the leadership within community mental health centers (CMHCs); their training and experience have been almost exclusively in the area of clinical treatment services. Thus, uncertainty among decisionmakers about the merits of preventive approaches and lack of exposure to the subject of prevention during professional training have contributed to the paucity of preventive activities within CMHCs.

Moreover, the consultation and education function (C & E), originally intended as the focal point for prevention planning and implementation within CMHCs, has been assigned activities which frequently are not representative of primary prevention. In some instances, C & E has become no more than a case-finding activity feeding the CMHC's treatment program. Other times, C & E has been charged with training gatekeeper personnel whose responsibilities are more characteristically secondary prevention. While the training of gatekeepers is an appropriate strategy in a comprehensive mental health program, such activity can be time consuming and of low yield for primary prevention if the gatekeepers are not carefully selected using as a major criterion the specific high risk populations to be reached. Lastly, in some centers C & E often has been assigned little more than a public relations role. Collectively, only 5 percent of CMHC staff resources nationwide, as indicated by NIMH biometric data, are devoted to C & E, and much of that effort is not directed to primary prevention.

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*The introductory portion of this section was adapted from the NAMH contract proposal to NIMH.

The absence of a commitment to prevention and the heavy emphasis on treatment serve to limit the attention of the CMHCs to those persons who present themselves for care. As a consequence, catchment boundaries have been seen simply as an additional intake criterion by which a patient is to be screened for eligibility to receive service. The concept of the catchment area as a basis for fixing CMHC responsibility to serve the mental health needs of a total population is missed by professionals who neither possess nor value a public health perspective. Such CMHC professionals appear satisfied as long as they are using their treatment skills with those who are "sick" and find their way to the center. These mental health workers are not aware of, therefore neither challenged by nor excited about, an obligation imposed by the catchment concept to be accountable for the development of a program to anticipate pathology in the population area and to intervene appropriately to remove the threat of pathologic behavioral responses which, if not prevented, will appear later as mental and emotional disturbances.

Given this appraisal of primary prevention in CMHCs, the National Association for Mental Health articulated the following premises aimed at the need to upgrade the status of primary prevention activities:

1. Changing the status of prevention within the CMHCs is clearly dependent upon changing attitudes of the key decisionmakers. Success in establishing prevention as an equal component with treatment will depend upon persuasive influence directed to this population.
2. Changing attitudes and building motivation among key decisionmakers require attention to the following factors:
   a. How will the program be financed? If the program is not supportable through supplemental funding, it is at a distinct disadvantage in competing with the inescapable demands for treatment services.
   b. What basis is there for claiming that prevention can actually be accomplished? How can it be done? What's in it for a CMHC to justify the time and energy required to adopt this activity?
3. The concept of accountability to plan for the mental health needs of the total population and the subpopulations of a catchment area, while understood in principle, is not part of the orientation of many CMHC leaders whose backgrounds emphasize treatment of disorders within a specific client or patient.
4. Consultation and education (C & E), although a required service, has become a term without precise meaning used to encompass and legitimize a variety of activities usually regarded to be of minor significance among CMHC top leadership. The

term "prevention" is used frequently in the same vague way to gain acceptance for a range of popular activities having little or no demonstrably significant preventive impact.

5. Nonsystematic activity applied to random populations for brief periods of time and dependent upon the personal interest and enthusiasm of one or a few CMHC staff members may be of some benefit to those to whom the program is extended, but there will not be any significant long-range implications deserving the description of "prevention."
6. Despite frequent references to the difficulty of defining prevention, definition is not the problem. There appears to be a resistance to the development of a precise definition because vagueness permits the use of the term, which is an esteemed term, in connection with a wide range of activities which could not conform to more rigorous demands. The following considerations relate to definition:
   a. The use of the word prevention should be limited to primary prevention. To refer to early treatment as secondary or rehabilitation activities as tertiary prevention contributes to the confusion and diminishes the usefulness of the term.
   b. Prevention is directed toward reducing the incidence of a highly predictable undesirable consequence. The term should not be used interchangeably with "promotion of mental health" or "improving the quality of life."
   c. Prevention is a term applicable to populations and not to individuals within those populations. Incidence within a population can be measured, and change in incidence can be demonstrated; but it is not possible, with rare exceptions in highly controlled situations, to prove that an individual who did not become the victim of a condition would without question have incurred the condition except for the preventive intervention.
   d. An activity deserving to be described as prevention should generally include the following elements:
      - a condition which can be observed and recorded in precise terms
      - an identified population at risk for that condition
      - a measure of the incidence of the condition in the population
      - a clearly defined plan of intervention applied to the identified population
      - the measurement of incidence following the intervention

Based on these observations and premises, the National Association for Mental Health approached the National Institute of Mental Health to secure funds to design, test, and evaluate a working model conference for promoting primary prevention programing within

local community mental health delivery systems. The proposal to convene this conference was perceived by both the NAMH and the NIMH as an opportunity to focus on many of the key issues of primary prevention noted previously.

The material presented in this volume was prepared in connection with the regional Pilot Conference on Primary Prevention conducted on April 2-4, 1976, at the Temple University Conference Center in Philadelphia, Pa., under the direction of the National Association for Mental Health in cooperation with the National Council of Community Mental Health Centers (NCCMHC); financial support was provided by the National Institute of Mental Health.

In compiling this document the editors opted to include information related to the process as well as the content of the entire conference project. Simply stated, the rationale was to provide sufficient detail to persons at the local level responsible for developing primary prevention training programs to enable them to adopt and adapt various aspects of the conference model design to their unique setting, as required. In addition, we believe this proceedings will be of value to the broad mental health constituency, including CMHCs, State and local mental health associations, and State mental health authorities, as well as mental health training institutions.

This volume has been organized into seven sections: (1) a description of the evolving conference design and its implementation, (2) the summary of a preconference survey on primary prevention programing by community mental health programs and centers in Pennsylvania and northern Maryland, (3) the texts of the three formal papers presented which deal with trends in preventive programming, basic strategies in designing preventive interventions, and ways of formulating and evaluating achievable objectives for primary prevention, (4) summary statements on the workshops which presented examples of primary prevention programing for specific target groups, described different approaches to establishing programs in community settings, and focused on program planning in relation to community involvement, funding, management and staffing, and evaluation, (5) a sample of outline plans for preventive programing prepared by teams of conference participants, (6) evaluation of the conference, and (7) recommendations arising from the Pilot Conference project.

Donald C. Klein, Ph.D.
Stephen E. Goldston, Ed.D., M.S.P.H.

January 1977

ACKNOWLEDGMENTS

In its conception and implementation, the Pilot Conference on Primary Prevention benefited from the energy, skills, and creativity of many groups and individuals. Numerous consultants throughout the United States provided information about promising programs and conceptual frameworks. Others assisted in the development of the preconference questionnaire and in processing data from the research and evaluation instruments. Members of the National Association for Mental Health Task Force (chaired by Helen Wright) and the four person committee for the project from the National Institute of Mental Health (coordinated by Ford Kuramoto) provided important advice, support, and guidance throughout the life of the project.

The faculty members and special resource people for the conference threw themselves into the undertaking with great enthusiasm and even greater competence. They worked hard over a short period of only 1 day to forge themselves into an effective working team whose affirming outlook and high commitment to the task transformed a good conference design into an exciting and rewarding experience. Administrative staff especially should be singled out for their outstanding work in making preparations for the conference, providing backup support at the conference site, and in helping conferees feel welcome and appreciated. The participants themselves, by accepting the challenge to become involved in an examination of issues and possibilities for primary prevention, made a significant contribution to the success of the effort.

Of all the individuals deserving appreciation, I would like to single out four for special mention: Richard Hunter, Project Director of the Pilot Conference, whose commitment to primary prevention and wise leadership made the conference possible in the first place; Stephen Goldston, whose personal support, broad background of knowledge in the field of primary prevention, and investment of energy and attention have contributed both to the substance of the conference and the publication of the proceedings; David Hartl, moderator of the Pilot Conference, whose technical assistance helped transform some general notions into an imaginative and effective design for a set of integrated working sessions;

and Lola Klein, who was actively involved in the administration and planning of this project.

Donald C. Klein, Ph.D.

This coda or supplementary acknowledgments section provides the Federal representative of this editing team an opportunity for brief commentary. From my professional perspective, this volume records the proceedings of a major event in the long-standing effort to advance an understanding, acceptance, and implementation of primary prevention programs in the mental health field. The success of the Pilot Conference is attributable largely to Don Klein's creative, productive efforts. Working closely with Don on the conference and in the preparation of this volume has been a rewarding experience in which I have benefited from his maturity, good sense, and optimism.

Appreciation also is extended to Leslie Dashew Isaacs, Primary Prevention Program Specialist, NIMH, who made substantial contributions to this volume.

Stephen E. Goldston, Ed.D., M.S.P.H.

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Chapter I

DESIGN AND IMPLEMENTATION OF THE PILOT CONFERENCE

DESIGN AND IMPLEMENTATION OF THE PILOT CONFERENCE

Background

This conference emerged out of concerns expressed by local and State mental health associations about the need to promote primary prevention programs. Responsive to their constituency, the National Association for Mental Health (NAMH) formed a Prevention Task Force in November 1973 to explore the feasibility of convening a conference which would address the relative neglect of primary prevention by mental health agencies throughout the Nation. The Task Force effort culminated in a decision to organize a conference which would emphasize primary prevention as a high priority component of comprehensive community mental health programing. Subsequently, contract funds were secured from the National Institute of Mental Health (NIMH) for the development, implementation, and evaluation of a regional Pilot Conference on Primary Prevention.

Under the terms of the contract, NAMH undertook to formulate and test a conference model designed for administrators and policymakers of local community mental health programs, particularly community mental health centers (CMHCs). The model was to address the following *objectives:*

(1) seek acceptance for and commitment to the concept of CMHC accountability for the mental health needs of the total population of a catchment area

(2) seek acceptance of the concept that the CMHC is a dual-focus system with equal concern for treatment and prevention, thus requiring a consequent elevation in status and function of the consultation and education (C & E) component in CMHC operations

(3) demonstrate skills in systematic identification of populations in a catchment area which constitute a homogeneous group at high risk for pathologic behavior responses

(4) demonstrate the application of standard interventions to high risk populations

(5) demonstrate the applicability of the scientific method to the intervention process for the purpose of producing acceptable measures of accomplishment

(6) obtain concurrence about the merits of increased support of prevention services among key decisionmakers who determine CHMC budget allocations

(7) be replicable on a regional basis so that identical objectives might be advanced throughout the total national CMHC system

Development of the Work Plan and Conference Design

The actual conference planning process began in September 1975 when Dr. Donald C. Klein was engaged as the Project Director. Shortly thereafter, a work plan was developed which set forth sequences of steps to be taken on conference design and arrangements, recruitment and selection of participants, materials development, publicity, and general project management. While the work plan was in preparation, a period of initial information gathering began in order to obtain background knowledge with respect to:

(1) the current state of primary prevention programing in CMHCs and other mental health facilities

(2) conference resource materials, e.g., papers, project descriptions, and other documents

(3) representative programs to be highlighted at the conference

(4) resource experts to serve on the conference staff

(5) the needs, interests, and potential receptivity of CMHC administrators and decisionmakers for whom the conference was intended

(This work plan was reviewed periodically with the NAMH Prevention Task Force chairperson, the NIMH Staff Planning Committee, and NCCMHC staff.)

Several approaches were used to secure the needed information:

(1) Literature searches were initiated through the NIMH Mental Health Clearinghouse and the ERIC facility of the U.S. Office of Education.

(2) Telephone conversations were held with selected informants in mental health programs, university centers, NIMH, and State mental health authorities.

(3) Data sheets were mailed to NCCMHC member agencies and distributed at two of their regional meetings requesting information about primary prevention activities which had been field tested with populations at risk (appendix A).

(4) Project staff participated in mental health conferences and meetings about C & E activities and mental health promotion; such involvements made it possible to confer with people representative of those whose needs should be met if the Pilot Conference was to have the desired impact.

(5) Formal and intensive consultations were begun with experts in the theory and practice of primary prevention in mental health settings.

On the basis of several contacts, certain *assumptions* were formulated to guide the work that followed:

(1) A fairly widespread and rapidly growing interest in primary prevention existed among mental health professionals, including a small but active group of administrators and policymakers at local and State levels.

(2) Board members and citizens were for the most part uninformed about, though generally receptive to, primary prevention programing.

(3) Confusion within the field resulted in a tendency to include primary prevention within C & E activities, thereby making primary prevention indistinguishable from secondary prevention and general mental health promotion and public education.

(4) General unawareness prevailed in the field about the public health approach to programing preventively for entire populations or subgroups at high risk.

(5) Isolated programs, well-documented and evaluated, demonstrated the applicability of available methods for the reduction of certain social and psychological disablements apart from the major mental disorders. However, information about these programs had not been widely disseminated among administrators and practitioners within local mental health programs.

(6) Prospective participants in the pilot conference would reflect a wide range of knowledge, experience, and attitudes about primary prevention. Many participants would have considerable ambivalence; however, in most cases positive attitudes would predominate.

Factors considered to influence favorable attitudes toward primary prevention included: (a) a professional commitment to prevention (and indirect services generally) as part of the federally funded CMHC mission, (b) curiosity about possibilities in this frontier aspect of mental health, (c) desire to keep one's agency in the forefront, (d) alertness to possible sources of funding for C & E under the new Federal legislation, and (e) responsiveness to primary prevention as a priority among the NAMH membership and other community persons.

Negative factors would include: (a) feelings of incompetence to plan, implement, and evaluate primary prevention programing; (b) threats to one's professional identity as a clinician; (c) professional and community pressures to treat those who are already "sick"; (d) vagueness about primary prevention as a program area; (e) skepticism about the effectiveness of primary prevention for dealing with major mental disorders; and (f) absence of a well-funded, high

priority thrust toward primary prevention at either State or Federal levels.

By December 1975, certain basic guidelines were formulated consistent with the assumptions stated above and integral to the design of an intensive working conference which would involve participants actively in the application of concepts and techniques:

A. With respect to participant selection:
   1. The selection should include persons already involved in and committed to primary prevention work within their own CMHCs.
   2. Every effort should be made to encourage, if not require, CMHCs to send teams of executives and decisionmakers, including the top administrator and either the president of the board or another member of the board's executive committee.
   3. Approximately one-third of the conferees should be representatives from organizations whose local, regional, and national support would be essential to the success of continuing CMHC programing for primary prevention, e.g., NIMH, State mental health authorities, State divisions and local chapters of NAMH, foundations, and others.

B. With respect to conference faculty:
   1. A nuclear team should include people from the basic mental health disciplines well versed in the application of public health concepts and methods to CMHC catchment area populations.
   2. A wide range of technical and substantive expertise should be represented with skills in strategies for program development, approaches to program evaluation, sources of funding, management and staffing of primary prevention activities, and the involvement of community groups and organizations in specific program development.
   3. In addition to able talent with special expertise drawn from across the Nation, the faculty should include resource people from within the target region. Such persons would be aware of local needs and conditions; their work would seem more plausible to colleagues and board members alike; and they would remain within the target region to offer consultation and technical assistance if needed.
   4. Most, if not all, of the faculty should possess the group and conferencing skills that would be needed in order to involve participants in a process designed to produce attitudinal and motivational changes as well as additional knowledge of concepts and techniques.

C. With respect to conference design:
   1. The varying levels of knowledge and experience brought by participants should be a key consideration.

2. Some initial experiences or inputs should be provided to help develop a common base of understanding and orientation to the topic of primary prevention.
3. The design should encourage the surfacing and discussion of doubts and concerns about primary prevention in order to contribute toward an exploration of concepts and techniques.
4. Clear, well-documented examples of carefully evaluated programs of known effectiveness should be presented.
5. Provision should be made for involving participants in a working process that would enable them to test and internalize their understanding of theory and strategies.
6. A preconference mailing should provide participants with a clear, unambiguous set of realistic expectations about their involvement.
7. A climate of inquiry should be built and maintained on a background of factual information and integrative concepts; participants should be encouraged to arrive at their own conclusions about the applicability of ideas and approaches to their own situations.
8. A resource room should be provided which would contain books, articles, abstracts, unpublished reports and papers, and other reference materials for use by participants during the conference.

Participants

Emphasis was placed on the recruitment of three-person participant teams composed of executives and decisionmakers from local programs. Announcements providing information about the conference along with application forms were mailed to all known mental health programs in the designated geographical area. Recipients were notified that, in order to increase the likelihood that the conference would result in actual program development, priority for attendance would be given to teams comprised of decisionmakers who by definition included the director and an officer of the board plus either the coordinator of C & E, the chief of research and evaluation, or a second board member. The conference participant selection procedure was based on the stated intent of agencies to agree to be represented by three-person teams.

Eighty-one participants, including teams of two or more persons representing 25 local mental health programs from Pennsylvania, Delaware, and northern Maryland, convened at the Temple University Conference Center in Philadelphia. The group included 13 CMHC directors, 19 coordinators of CMHC consultation and education (C & E) or primary prevention programs, 14 members of

CMHC policy or advisory boards, and 14 other professional mental health staff members. The remaining participants were mostly from NIMH, State mental health authorities, and State divisions and local chapters of NAMH. A list of conference participants is included in appendix B.

The effort to limit participation to administrators and policymakers was only partially successful. Three of the mental health programs indicating a desire to participate in the conference fell short of the team criteria. However, as the time for the conference approached, the directors of nine agencies which had been selected to participate decided for various reasons to send other staff members in their place, and almost half the board members either withdrew in advance of the meeting or simply did not attend. (This experience suggests cause for concern about the extent of commitment to primary prevention represented in the original acceptance of the conference invitation.)

Conference Faculty

The resource team assembled probably exceeded the requirements for conference faculty described above. The core team of 11 persons was coordinated by a specialist in adult and continuing education who served as conference chairperson and convenor of general sessions. The faculty included four members with a strong public health orientation, a former CMHC program director, three experts in the epidemiology of mental health, two people with direct experience in the planning and implementation of primary prevention programs at the local level, and five members with extensive backgrounds in involvement of community groups in mental health programing. Professional members of the core team included four community psychologists, two social workers, a psychiatrist, a sociologist, a social psychologist, a developmental psychologist, and a public relations specialist. The core team was supplemented by four special resource people who prepared and conducted workshops on primary prevention programing for specific target groups. Practitioners, researchers, planners, and theoreticians were represented on the faculty.

Setting Preconference Expectations

A packet of materials on conference substance and arrangements was mailed to each participant 2 weeks in advance. The contents included: a covering memorandum which set forth the objectives of the conference, the underlying philosophy, and the expectation that the participants would be active and involved (appendix C); a

copy of the conference program (appendix D); listings of the NAMH Prevention Task Force (appendix E) and the NIMH staff planning committee (appendix F); brief biographical sketches of faculty members (appendix G); and a copy of the monograph by Muñoz and Kelly entitled *The Prevention of Mental Disorders.** Thus, a deliberate effort was made to establish an informal, yet business-like and hard-working climate prior to the opening of the conference.

The Conference Program

The basic elements of any conference are: the design including the substantive content, the conferees, the faculty or resource people, the physical setting, the means whereby participant expectations are established prior to the opening session, and the procedures whereby the conference is monitored in terms of its success or failure in reaching its objectives. Ideally, the elements are orchestrated so that each contributes to and reinforces the others.

A schematic presentation of the conference design elements and their interrelationships is shown in figure 1.

The opening session began with a presentation of selected findings from the preconference mail survey, emphasizing issues and concerns identified by respondents. Initial formal papers gave an overview of primary prevention programing and of strategic approaches to program design to establish at the outset a common base of understanding and orientation to the subject matter.

By noon of the second day, conferees had been exposed to two sets of concurrent workshops, each of which was designed to give clear, well-documented examples of carefully evaluated programs of known effectiveness. Subsequently, it was possible to involve participants in four and five person work groups, heterogeneously composed to represent the various constituencies of the conference; each group was given the task of outlining plans for primary prevention programing for a designated at-risk target population.

By midmorning of the third day, emphasis shifted to applications of learnings to the participants' own settings; members of mental health program teams met to develop work plans focused on primary prevention programing for their own locales (appendix H). At the same time, conferees from local, State, and national offices of NAMH, State mental health officials, and representatives from NIMH met as a group to consider the implications of the conference

*Muñoz, R.F., and Kelly, J.G., *The Prevention of Mental Disorders*. Homewood, Ill.: Learning Systems Company, 1975. 50 pp.

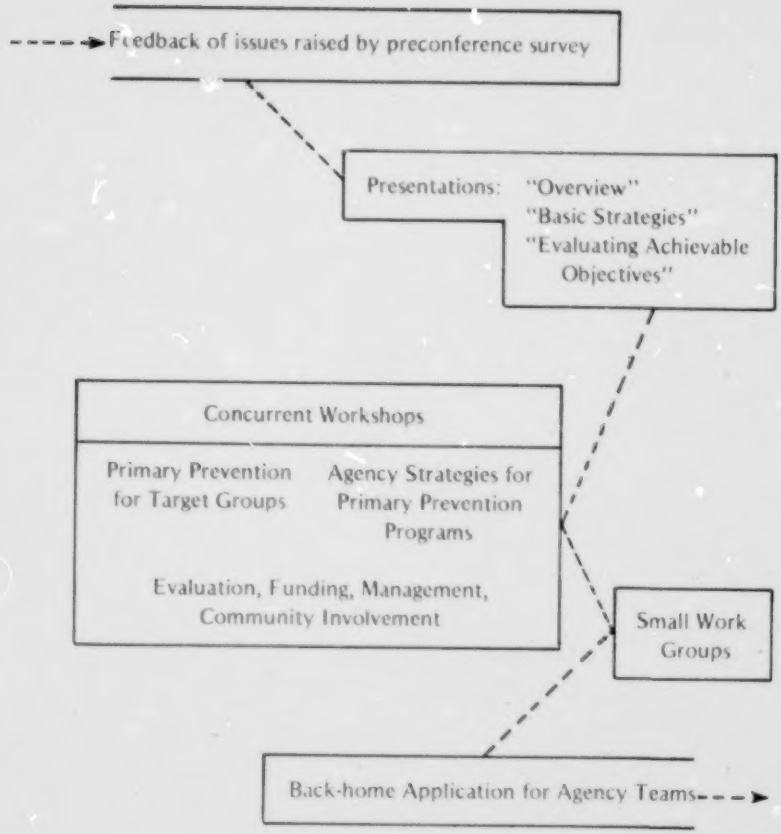
Feedback of issues raised by preconference survey
Presentations: "Overview"
"Basic Strategies"
"Evaluating Achievable Objectives"
Concurrent Workshops
Primary Prevention for Target Groups
Agency Strategies for Primary Prevention Programs
Evaluation, Funding, Management, Community Involvement
Small Work Groups
Back-home Application for Agency Teams

Figure 1: Conference Design Elements and Their Interrelationship

experience in terms of their supportive roles in relation to local programs. As a final step, local teams were drawn together in clusters composed mostly of agencies within the same metropolitan areas, with the hope that sharing and consultation on back-home plans would establish a possible basis for continuing interagency support and technical assistance. The conference closed with a general session with discussion on remaining questions, issues, and concerns identified by the participants.

Chapter II

SUMMARY REPORT OF PRECONFERENCE SURVEY ON PRIMARY PREVENTION PROGRAMING

SUMMARY REPORT OF PRECONFERENCE SURVEY ON PRIMARY PREVENTION PROGRAMING*

The survey on Primary Prevention Programing was sent to all known directors of community mental health programs, including CMHCs, in Pennsylvania, Delaware, and northern Maryland; the survey questionnaire is in appendix I. The purpose of the survey was to obtain the following kinds of information on primary prevention: types of groups and institutions involved in such programs; patterns of staffing, management, and funding; and relevant factors affecting commitment to primary prevention. Thirty-four of 81 programs (41 percent) responded; 24 of the 34 expressed interest in attending the pilot conference. Probably the 34 programs which responded were more involved and interested in primary prevention collectively than the 47 nonrespondents. This report summarizes those findings that highlight important issues or concerns which are deemed to be of special interest to participants in the pilot conference.

Characteristics of the 34 Programs

Over half the programs serve catchment areas of from 100,000 to 149,000 people; the average is 148,952, the range from 84,000 to 230,000. Forty-four percent of the programs are located in urban settings, 38 percent serve mixed urban and rural areas, and 18 percent serve rural areas.

The programs have been in operation on the average less than 7 years (mean = 6.8; range being from less than 1 year to 18 years). These figures emphasize that the community mental health movement is still in its early years, though some of its roots extend back to the years leading to and following World War II.

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*Note: The term "programs" is used in this report to refer to local community mental health agencies, including CMHCs.

Whites constitute about 80 percent of the populations served, blacks about 14 percent, Spanish-speaking about 1½ percent, and Asians less than 1 percent. These figures may be somewhat low. Two programs responded 90 percent and 97 percent to the category "Native American," which is commonly used to refer to "American Indians." The average for Native Americans, therefore, was 2.9 percent, a figure that does not reflect the real state of affairs in these three States.

Programs vary considerably in the racial composition of their catchment areas: the percent of blacks ranges from 0 to 82 percent; the percent of whites from 0 to 99.5 percent.

Taking 10 percent as the dividing point, the following table shows that programs are about evenly divided between those serving population areas that are predominantly white and those that have a significant proportion of blacks:

White/Nonwhite ratio	Number	Percent
Ten percent or more nonwhite	17	52
Nine percent or less nonwhite	16	48
No response	1	—

Other characteristics are listed below:

Characteristic of the program	Percent "Yes"
1. Is the program a consortium or grouping of separate agencies and programs?	15
2. Does the program have separately located outreach facilities?	82
3. Has the program formulated a specific written policy about primary prevention?	26
4. Are you in the process of developing a policy about primary prevention?	56
5. Is the program a federally funded comprehensive community mental health center?	67
6. Does the program serve a poverty designated area?	53

The majority of programs are single agencies, centrally governed and administered. On the other hand, most programs (82 percent) operate in part through decentralized outreach facilities. Considering items 3 and 4 together, about 8 out of 10 programs (82 percent) either already have or are developing an explicit policy about primary prevention. Since, nationwide, perhaps 2-3 percent of time is devoted to primary prevention, it is noteworthy that so many of the 34 programs responded affirmatively to items 3 and 4. Finally, the programs are about evenly divided concerning service to poverty designated areas.

Time Devoted to Prevention

The survey inquired about the percent of overall staff time devoted both to primary and secondary prevention approaches. Estimated time devoted to primary prevention ranged from six programs which responded zero (0) to two programs which indicated 90 percent and 99 percent. Because these two figures are at one extreme in comparison with all other programs, the median rather than the arithmetic mean is used to present the average of all responses. All but four programs fall between zero and 10 percent of staff time; the median is *5 percent of staff time.* The comparable figure for secondary prevention is 10 percent. For this survey, secondary prevention was defined as activities dealing with specific target groups, early identification of symptoms, and facilitating early treatment, as differentiated from generalized, nonspecific treatment services.

The best available national estimates for the amount of time devoted to Consultation and Education activities by CMHCs is around 5 percent. Therefore, the programs responding to this survey appear atypical in that far more time is reported to be devoted to indirect services in comparison with national averages.

Nevertheless, the programs expressed dissatisfaction with the percent of time being allocated to primary prevention. The survey asked: "Ideally, what percent of staff time would you like to be able to devote to primary prevention programing?" The median response was 20 percent; the range from 2.5 percent to 99 percent.

On the average, the survey suggests that programs involved in the pilot conference are devoting about 5 percent of staff time to primary prevention now and would like to raise that figure to 20 percent in the future.

Factors Affecting Time Devoted to Primary Prevention

What factors affect the time devoted by programs to primary prevention? The survey approached the question in two ways: first, by comparing time devoted with the characteristics of programs, such as the size and nature of the populations served; second, by asking directly about the relative influence of certain factors on the amount of effort devoted to primary prevention.

Program Characteristics and Time Devoted

We had expected to find some characteristic differences between programs heavily involved in primary prevention and those less in-

volved, such as the size of population served, the proportion of nonwhites in the population, whether or not the program had developed written policies about primary prevention as a function, and whether primary prevention activities were carried out by a full-time team or simply as add-on activities to staff work loads. None of these predictions was borne out in the survey. There were low positive correlations between estimates of actual time devoted to primary prevention and percentage of blacks in the catchment area, number of years the program had been in operation, whether or not a policy on primary prevention was being developed, and whether or not the program is a federally funded CMHC. None of the correlations was statistically significant; all could have occurred due to chance variations in sampling.

Perceived Influence of Certain Factors

The survey presented a list of 13 factors which, depending on circumstances, might tend either to reduce or increase the amount of effort devoted to primary prevention by a program. The factors had to do with funding, staff skills and attitudes, confidence in available methods, community and board attitudes, and the perceived importance of primary prevention as a mental health function. Each factor could be rated as either reducing or increasing effort, or having no effect.

The following eight factors, listed in decreasing order of perceived influence, were viewed as tending to increase effort more often than reducing it:

(1) number of at-risk groups for whom programs are needed
(2) number of staff with needed skills
(3) importance of primary prevention as a mental health function
(4) policy reflected in Federal guidelines
(5) level of staff interest in primary prevention
(6) availability of methods to do the job
(7) level of community support for primary prevention
(8) level of priority given to primary prevention by board members

Only one factor was placed about equally on both sides—program's prior experience with primary prevention activities—possibly indicating that those responding have had both favorable and unfavorable experiences with previous attempts to engage in primary prevention work.

Four factors were viewed as reducing effort more often than increasing it. In decreasing order of perceived influence, these factors were:

(1) available funds for primary prevention
(2) amount of effort required for direct service demands

(3) ability to evaluate program effectiveness
(4) policy reflected in State guidelines

Respondents to the survey seem to be saying that primary prevention is a significant mental health function, that staff members with skills to do the job are available, and a generally favorable attitude to primary prevention prevails among both staff members and community people. However, there are significant obstacles, such as the lack of available funds for doing the job and the competition of direct service demands for scarce resources of staff time and program funding. Better methods for evaluating primary prevention programing and more actively favorable policies at the State level also would be helpful.

The survey also asked for "the major frustrations anticipated or experienced in delivering primary prevention programs." A content analysis of the responses came up with eight factors: (1) funding problems, (2) gaining community acceptance, (3) lack of knowledge and skills, (4) difficulties in evaluation, (5) competition with direct services, (6) limitations of staff in numbers, (7) lack of administrative or staff interest and support, and (8) difficulties in setting goals and priorities for primary prevention. The following table indicates the frequency and the percent of programs noting each factor:

Factor experienced or anticipated as a major frustration in delivering primary prevention	Frequency	Percent of programs
1. Funding problems	20	69
2. Gaining community acceptance	9	31
3. Lack of knowledge and skills	7	24
4. Difficulties in evaluation	7	24
5. Competition with direct services	7	24
6. Limitations of staff in numbers	6	21
7. Lack of administrative or staff interest and support	4	14
8. Difficulties in setting goals and priorities	4	14

Focus of Effort

The survey presented a list of 15 institutions and community groups and asked respondents to identify which ones they were collaborating with on a regular basis in order to carry out primary prevention work. Nine out of 10 programs reported regular contact with the public schools, better than two-thirds with social service agencies and programs for preschool children. Almost two-thirds reported regular contact with clergy, law enforcement agencies, other mental health facilities, and public health departments or

other health agencies; over half with youth-serving organizations. The following table lists the percentage of programs by type of institution cited:

Type of institution	Percent of programs
1. Public schools	90
2. Social service agencies	73
3. Nursery schools or day care programs	67
4. Clergy	63
5. Law enforcement agencies	60
6. Other mental health facilities	60
7. Public health dept. or other health agencies	60
8. Youth-serving organizations	53
9. Mental health associations	43
10. A.A. or other self-help groups	43
11. Physicians	33
12. Family planning services	27
13. Community planning agencies	17
14. Employment services	14
15. Service clubs	7

Institutions or groups added to the list by respondents included:

Agency on aging
Hot line volunteers
Public housing project
Agencies serving the blind
Local college
Veterans' organization
Pediatric service
Maternity service
Obstetrics clinic
Burn unit
Parents Anonymous

The survey also presented a list of 22 target groups for primary prevention efforts. Respondents were asked to check each group for which a specific activity had been developed. Over half the programs reported primary prevention activities for preschool, secondary, and elementary schoolchildren in that order. By contrast, however, relatively infrequent citations were made of other groups ordinarily considered to be at high risk (e.g., parents-to-be and new parents, unemployed persons, bereaved individuals, and those facing retirement). The following table lists percentage of programs mentioning each type of group:

Target groups	Percent of programs
1. Preschool children	63
2. Secondary school children	63
3. Elementary school children	57
4. Children and families at school entry	40
5. Families with severely handicapped children	40
6. Poor people	40
7. Single parents	33

continued

Target groups	Percent of programs
8. Families with a chronically ill or disabled member	33
9. Disadvantaged and oppressed ethnic groups	30
10. Families with a hospitalized member	27
11. Predelinquents	27
12. Adult singles	23
13. Disaster victims	17
14. Parents-to-be	17
15. New parents	17
16. Chronically unemployed	7
17. Bereaved persons	7
18. Pre- or postretirees	7
19. Newly unemployed persons	3
20. New comers	0
21. Engaged couples	0
22. Migrants	0

At risk groups added to the list by respondents included:

- Foster parents
- Women
- Teachers
- Learning disabled children & parents
- Families of alcoholics
- Ex-hospitalized after-care patients
- Parents
- Newly divorced or separated people
- Local college counselor staff

Mental Health Program Needs in Regard to Primary Prevention

The survey listed nine areas of possible need which might be addressed by the conference. Respondents were asked to indicate whether each need was "not important," "somewhat important," or "very important." The list included items having to do with sources of funding, evaluation and programing techniques, approaches to community involvement, and the management of primary prevention programs. An average need rating was developed by assigning point scores to the three levels of importance. No area of need was scored below 2.0 which represents "somewhat important." Items approaching an average score of 3.0 ("very important") included: (1) help in securing adequate funds, (2) techniques for evaluating primary prevention efforts, and (3) staff development training to help program staff members learn how to plan and conduct primary prevention work.

The following table reflects the relative importance attached to the different areas; the average need scores are listed in rank order:

Area of need in regard to primary prevention	Average need score	Percent of programs rating "Somewhat" or "Very Important"
1. Help in securing adequate funds for doing primary prevention work that is needed	2.8	96
2. Techniques for evaluating primary prevention efforts	2.7	100
3. Staff development training to help staff members learn how to plan and conduct primary prevention work	2.6	93
4. Help in developing effective primary prevention programs for designated "high-risk" groups	2.5	94
5. Techniques for assessing community needs in the area of primary prevention	2.4	94
6. Techniques for motivating community groups to work on primary prevention projects	2.4	89
7. Improved ways of organizing and managing primary prevention activities	2.2	83
8. A mandate from community groups to carry on primary prevention work	2.0	63
9. A mandate from the agency board to engage in primary prevention work	2.0	64

Chapter III

FORMAL PAPERS

This chapter includes the three formal papers presented at the conference general sessions. The purpose of each paper was to provide the participants with a common background of information prefatory to their assembling into work groups to design primary prevention programs for specific high-risk populations. These papers deal with fundamental and essential perspectives on primary prevention: an overview or state-of-the-art of primary prevention, basic strategies in designing primary prevention programs, and considerations in determining and evaluating achievable objectives for primary prevention.

AN OVERVIEW OF PRIMARY PREVENTION PROGRAMING

Stephen E. Goldston, Ed.D., M.S.P.H.

Introduction

The major purpose of this presentation is to assist in setting the tone and direction of this conference by (1) identifying some of our common roots and understandings, (2) outlining what I believe to be the state of the art of primary prevention, (3) citing some principles and problems, and (4) offering a thought for inspiration. Accordingly, I hasten to state that this is a mental *health* conference. And how could it be otherwise when we have come together under the joint auspices of three national leadership organizations which within their agency titles share a single designation—the National Association for *Mental Health*, the National Council of Community *Mental Health* Centers, and the National Institute of *Mental Health*.

We are here to talk, learn, and plan about mental health, not mental illness—*positive* mental health as identified with its many and varied meanings by Jahoda in *1958*.

A sense of history is invaluable in helping us to understand where we are, where we seem to be headed, and how we can influence future events.

The year 1958 also witnessed another milestone mental health meeting—the National Assembly on Mental Health Education held at Cornell University in Ithaca, N.Y. under the cosponsorship of two of the organizations represented here tonight—the NAMH and Pennsylvania Mental Health, Inc. What transpired at that meeting 18 years ago is relevant as we begin our deliberations, since the focus then also was on positive mental health.

The 1958 Assembly dealt with "educational activities supposed to be useful in preventing or minimizing mental illness or designed to improve mental health"; relevant issues included (a) a definition of mental health, (b) the goals of mental health education, (c) principles of mental health sufficiently grounded in scientific findings and clinical experience to serve as the basis for a mental health

education program, (d) preferable educational techniques, and (e) priority areas for future exploration. Despite a mental health focus, the proceedings document records "a main battle line was drawn at Cornell between those focussed on mental illness and those focussed on positive mental health. There was no final rapproachement . . ." (Pennsylvania Mental Health, Inc., 1960). What did emerge from that National Assembly was a "nuclear consensus of principles which appear to be basic to mental health education." These four principles, or "beginning consensus," were identified:

> Human behavior is caused; it is not random, no matter how bizarre or deviant it may appear.
>
> Most human actions are complicated and are a product of many causes. By no means are all known.
>
> Human behavior is determined by emotional drives which sometimes compete with rational considerations; human behavior is influenced, in part, by unconscious motivation, which is relatively refractive to logic and 'will power.'
>
> The need to be stimulated and protected is present in all human infants. Furthermore, a need to be loved and the ability to love, which begins in early infancy, leads to the need to love which seems a crucial aspect of human behavior.

And the Assembly summarizers concluded: ". . . this short, rather general statement of belief about human behavior appeared to exhaust the area of agreement among all the groups. Perhaps in this field we are not ready to formulate a set of more complete and specific working principles. This, in itself, is an important finding from Cornell."

Let us presume that the 1958 meeting accurately mirrored the state of the art within the mental health field with respect to "positive mental health," or, if you wish, mental health education. More probably it reflected confusion about community mental health, or primary prevention, or whatever was perceived by those present to belong outside the scope of clinical concerns. If, for the sake of argument, we would accept the Cornell summary as the state of the art circa 1958—then as the commercial says "we've come a long way, baby." And with that as preface, let us move together into what I believe to be the state of the art of primary prevention, vintage 1976.

State of the Art of Primary Prevention

A proper starting point would be acknowledging that the basic principles and practices of primary prevention emerge out of our commonly shared ideology about community mental health—specifically, but not limited to, those tenets of community mental health which affirm:

(1) a commitment to raising the level of mental health of the *entire* community, not just the psychiatric casualties who appear at the doors of mental health facilities seeking direct treatment services;

(2) involvement in community institutions and community systems accompanied by an awareness that the mental health enterprise is but one among many help-giving agencies concerned with the mental health of populations; and

(3) the relevance of public health concepts and practices, especially such notions as populations at risk, incidence rates, and epidemiological techniques and analyses. In addition, two other concepts derived from public health are part of our common ideology: (a) No condition has been controlled or prevented merely by treating the victims, i.e., community approaches, public health approaches (as opposed to early diagnosis and treatment) are required to effect control; and (b) A key question is "how well is the community"? rather than "how sick"?

Within this context, primary prevention is possible, feasible, and necessary.

Frameworks for Conceptualizing Primary Prevention

In my view, there are four specific, distinct major frameworks for conceptualizing and classifying primary prevention efforts:

(1) Primary Prevention of the Mental Illnesses of Known Etiology

Basically, this framework involves a medical approach focused on those conditions of *known* etiology which it is possible to prevent by "specific protection" interventions. The aim is to avoid the onset of mental disorders by intercepting the causes of disease before people become exposed. In the medical/psychiatric sphere sufficient scientific evidence exists to prevent some mental disorders, including both acute and chronic brain syndromes, resulting from (a) *poisoning* by certain substances, e.g., lead-based paints, (b) *infections*, e.g., encephalitis, rubella, syphillis, (c) *genetic diseases*, e.g., PKU, galactosemia, (d) *nutritional deficiencies*, e.g., pellagra, beriberi, (e) *general systemic diseases*, e.g., erythroblastosis fetalis, cretinism, and (f) *accidents and other physical traumas* (American Public Health Association 1962).

Operationally, primary prevention of the mental illnesses of known etiology has become the responsibility of public health and environmental protection agencies. By and large, mental health workers are neither involved in programs aimed at the primary prevention of the mental illnesses of known etiology nor are they generally aware of the multiple opportunities, buttressed by incontestable research findings, to effect the prevention of many conditions which result in diagnosable mental illness. Were the unique contribution of mental health workers, namely their expert knowl-

edge of human behavior, applied to such public health/mental health functions as community poison control programs and communicable disease immunization programs, one anticipated consequence might be a reduction in the incidence of new cases of those disorders which can result in mental illness.

(2) Primary Prevention of the Mental Illnesses of Unknown Etiology

For perhaps a majority of mental health workers, this is the most familiar conceptual framework of primary prevention. It is the framework most frequently evoked by skeptics who maintain that it is impossible, if not absurd, to pursue primary prevention activities in the absence of knowledge of the etiology of the major mental illnesses, such as the schizophrenias and the depressions.

In my view, in the absence of scientific research findings on etiology, it is a disservice to the contribution which we presently have the capacity to make to contaminate our task and diffuse our limited energies and resources by even addressing issues relating to primary prevention of the mental illnesses of *unknown etiology*. Current knowledge of the etiology of the *major* mental illnesses is limited; consequently, generalized, nonspecific efforts purported to be aimed at the primary prevention of these disorders warrant considerable suspicion. In this connection, I want to underscore a guideline in the planning and conduct of primary prevention efforts: All primary prevention activities must be characterized by *specific* actions directed at *specific* populations for *specific* purposes.

(3) Primary Prevention of Emotional Distress, Maladaptation, Maladjustment, Needless Psychopathology, and Human Misery

This framework entails a psycho-socio-cultural-educational approach in which crisis theory, crisis intervention, and anticipatory guidance are particularly relevant. Counseling, mental health consultation, community organization, training of vital community caregivers, and mental health education serve as the major forms of professional mental health activity. The objective as the designation indicates is to reduce or obviate unnecessary emotional distress, when possible. For example, more general awareness by bereaved persons of the universal signs and symptoms experienced during an acute grief reaction probably would reduce the anxiety occasioned by the presumption that one is "losing his mind" during this time of crisis.

(4) Promotion of Mental Health

Similar to the third conceptualization, here too the framework is that of a psycho-socio-cultural-educational approach. The objective is to promote social and functional competence, coping capacities, ego strengths, and "positive mental health." Again, crisis theory and

mastery of developmental tasks are basic constructs which are augmented by other theoretical orientations to be noted later. Consultative, educational, training, and organizational modalities are of major significance. Illustrative areas are family-life education, including parent education, sex education, and death education, as well as affective education at home and in the schools.

A key factor both in the conceptualization of the Primary Prevention of Emotional Distress and the Promotion of Mental Health is the identification of individual and community strengths, rather than deficits or weaknesses (Klein 1969).

From my perspective, this conference is concerned with the two latter frameworks of primary prevention—the Primary Prevention of Emotional Distress on one hand and the Promotion of Mental Health on the other. We shall be engaged in learning about, exploring, and planning actions directed toward (a) *anticipating* a disorder and hopefully either eliminating or reducing its consequences and (b) fostering optimal mental health.

Definition of Primary Prevention

Within the conceptual framework presented, I have been guided by the following operational definition of primary prevention which has evolved from my work:

> "Primary prevention encompasses those activities directed to specifically identified vulnerable high-risk groups within the community who have not been labeled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives" (Goldston 1977).

I would suggest that a need exists for a standard meaning of the term "prevention" to avoid confusion and semantic difficulties. The term "prevention" should be used solely to refer to actions which either (1) *anticipate* a disorder and/or (2) foster optimal health. Under these conditions the term "prevention" would be synonymous with primary prevention.

Objectives of Primary Prevention

Consistent with the conceptual frameworks outlined and the definition presented, the overall objectives of primary prevention are twofold:

(1) to reduce the incidence of new instances of emotional distress or disturbance, and

(2) to promote emotional robustness (Bower 1963).

In my view, the paramount goal of primary prevention is to facilitate the achievement of personal, social (interpersonal), and functional (impersonal) competency—a conceptual framework initially expounded over 20 years ago (Foote and Cottrell 1955) and subsequently elaborated upon by a number of thoughtful, prestigious social scientists (White 1959, 1963, 1971; Smith 1965, 1966, 1968, 1974; Rae-Grant, Gladwin, and Bower 1966; Phillips 1967).

Briefly stated, the strategies for approaching the goals of primary prevention are twofold:

(1) strengthening individual capacities and/or decreasing individual vulnerabilities

(2) environmental modifications through planned social change

Summary of the State of the Art

In summarizing the state of the art of primary prevention, we can identify a number of assets:

(1) both an *ideology* shared with community mental health philosophy and practice and a *conceptual framework* for primary prevention work

(2) applicable *theoretical orientations* including but not limited to crisis theory, social systems theory, self-actualization theory, social competency theory, learning theory, and psychoanalytic theory

(3) an *operational definition*

(4) theoretical and practice-derived *models* for action

(5) *strategies* derived from public health practice and community mental health experience

(6) knowledge about developmental tasks at each life stage

(7) a *technology* for practice, including mental health consultation, crisis intervention, anticipatory guidance, mental health education, and community organization

(8) a growing *body of experience* in the conduct of primary prevention programs, particularly crisis intervention and educational approaches

(9) *applicable research methodologies* for the acquisition of new knowledge as well as the assessment of ongoing programs

(10) a *wealth of scientific research findings* waiting to be applied

These are our "riches"—let me now point to the realities on the other side of the ledger which record:

(a) a long history of neglect and skepticism among our colleagues

(b) insufficient administrative support and fiscal resources for both practice and research

(c) general confusion and misunderstanding about primary prevention among our detractors

(d) certain barriers which must be removed in order to pursue primary prevention work

Every primary prevention activity (including this conference) should assume as part of its agenda the task of reducing the barriers to primary prevention. These barriers are listed under the following eight categories:

(1) The argument of need for "scientific proof" is used to support the claim that primary prevention lacks sufficient scientific evidence to underpin action.

(2) Prevention has little or no political clout, i.e., no constituency.

(3) "Prevention is everybody's business"—and we all know what happens when the presumption prevails that everyone shares a responsibility.

(4) The training of mental health leaders is mainly clinical with little, if any, exposure to primary prevention.

(5) Few professional mental health workers are assigned to primary prevention activities on a sustained, full-time basis.

(6) Fiscal allocations for primary prevention are pitifully small at best, at worst, nonexistent.

(7) Value-oriented resistances in our culture block primary prevention efforts, e.g., our unconscious need for scapegoats, health being a value only in times of illness, and arguments regarding interference with rights of privacy (Bower 1961).

(8) The barrier of professional values is in my view the most important of all. So long as public health values are regarded by mental health workers as inferior to clinical values, primary prevention efforts will lag. In *Julius Caesar*, Shakespeare put it this way: "The fault, dear Brutus, is not in our stars, But in ourselves. . . ." Walt Kelly said it even better in *Pogo*: "We have met the enemy and they are us."

The Field of Forces

Notwithstanding the barriers, over the past 3 years there has been a renaissance of interest in primary prevention. Indeed, this conference is both a result of the emerging concern about primary prevention as well as a stimulus for increasing commitment at Federal, State, and local levels on behalf of primary prevention efforts.

A varied field of forces would appear to be related to the emergence of primary prevention as a respectable area for consideration by mental health workers, including such factors as:

(a) the public consumer movement which has been characterized by a greater sharing of information previously restricted to professional workers and the raising of questions and issues heretofore either ignored or overlooked

(b) growing awareness that primary prevention activities can contribute to eventual reduction of health care costs, e.g., hospi-

talization, etc.—an ounce-of-prevention philosophy with economic considerations

(c) genuine interest and growing commitment in the field about translating into action community mental health principles dealing with primary prevention

(d) the identification of prevention as one of five program emphases in the *DHEW Forward Plan for Health* over the next 5-year period. Key policy planners and decisionmakers within the Federal health and mental health establishments have indicated that prevention merits high priority.

Moreover, on a recent occasion the Assistant Secretary for Health of DHEW* said: ". . . I do feel very strongly that we need to build the preventive side, the health maintenance and promotion aspect of health. To do that, we need to shift our emphasis and begin to make commitments to prevention commensurate with its potential for improving our national health status. . . ." (Cooper 1975).

Such comments portend a favorable omen and point to an evolving favorable climate for primary prevention. Yet, only the sanction has been forthcoming, not the mandate for action.

As one who labors full time in the area of primary prevention, perhaps the most significant factor in my immediate professional field of forces has been active involvement in program development and implementation. For purposes of illustration, let us turn now to some specific primary prevention activities directed to specific populations.

The Sudden Infant Death Syndrome: A Fascinating Opportunity for Primary Prevention

A substantial portion of my primary prevention work over the past 2 years has been devoted to the area of death, initially to the mental health aspects of the Sudden Infant Death Syndrome (SIDS) and subsequently to various programmatic spinoffs which I will mention later. Out of this work has evolved a *model* for primary prevention program development as well as some principles or guidelines for community mental health workers responsible for primary prevention activities.

Some background about the problem of Sudden Infant Death Syndrome (SIDS) or crib death is a necessary preface to this discussion: Annually between 7,500 and 10,000 babies die from a real disease called the Sudden Infant Death Syndrome; the cause is unknown and death strikes quickly and silently, almost always during a period of sleep; SIDS can neither be predicted nor prevented; and

*Dr. Theodore Cooper, Assistant Secretary for Health, DHEW, until January 1977.

surviving parents and siblings are characterized by a pervasive grief/guilt reaction which often results in severe family dysfunction, divorce, disability, including psychiatric sequela (Bergman et al. 1969; Beckwith 1973).

Perceiving SIDS as a public health problem with pronounced mental health components, a framework for program development was devised at NIMH based on four guiding principles:

(1) Within a public health perspective, a primary prevention approach would be used in attempting to meet the mental health needs of surviving parents and siblings of a SIDS victim.

(2) SIDS program activities would be viewed as an opportunity for initial explorations, as a prelude to major emphases, into the areas of death, dying, grief, bereavement, needs of surviving family members, and death education, including anticipatory guidance about death.

(3) SIDS program activities could demonstrate the feasibility and productivity of primary prevention approaches and thereby encourage future programs focused on other specific life crises.

(4) Mental health personnel have a responsibility to work cooperatively with public health people on public health/mental health problems.

NIMH's first official SIDS activity was awarding a contract to the National Sudden Infant Death Syndrome Foundation, Inc. (NSIDSF) for a 2-year period commencing June 1974. The contract underwrites educational, counseling, and community organization activities in selected cities, States, and counties aimed at developing health/mental health service delivery networks and strengthening existing community agencies and personnel—namely, health departments and medical examiners/coroners' offices—to enable them to deal in an organized systematic fashion with the complex human problems associated with SIDS.

The ultimate objective of this activity has been to mobilize resources and create mechanisms which would serve to obviate the pervasive grief/guilt reactions characteristically experienced by families of SIDS victims. From this viewpoint, the NIMH and the NSIDSF are cooperating in a preventive psychiatry project within the framework of primary prevention, that is, attempting to reduce the incidence of persons possibly becoming mentally ill or severely emotionally disturbed as a result of the life crisis occasioned by SIDS.

Shortly after the contract became operational, a comprehensive program plan was promulgated to deal with the mental health aspects of SIDS with funds to be obtained under the SIDS Act of 1974. Unfortunately, the anticipated funds were not forthcoming. Therefore, new strategies were developed to deal with the mental health dimensions of SIDS.

Interviews with SIDS parents presented firsthand opportunities to learn how surviving family members experience and cope with the loss of an infant. Four major observations emerged from discussions with bereaved family members:

(1) The mental health dimensions of SIDS were considerably greater than had been originally envisaged either by NIMH or NSIDSF.

(2) SIDS parents appeared to have special difficulties in handling their infant's death vis-a-vis the surviving siblings; in addition, these parents have the same lack of information and abundance of anxieties about discussing death with children as do almost all parents in American society.

(3) Most bereaved family members will not reach out for help from either a mental health facility or private practitioner, partly because of a lack of awareness of the existence of such resources, but largely because to do so, in their view, carries a stigma. In addition, those family members who reported seeking the assistance of mental health workers said they did not obtain meaningful help, in most instances because mental health workers collectively are uninformed about SIDS in particular and about dealing with the crisis of grief and bereavement in general. Lastly, mental health agencies are not organized to provide prompt effective service delivery to SIDS families.

(4) Mutual-help groups composed of parents of SIDS victims are effective mental health resources for newly bereaved families.

These observations along with knowledge gained from increasing involvement with the mental health issues of SIDS affirmed the appropriateness and soundness of approaching this problem from a public health/mental health perspective. Basic to this perspective was the notion that knowledge gained about the mental health aspects of SIDS and the needs of surviving family members could be used to assist *all* parents and children in achieving a better understanding, awareness, and acceptance of death as a normal part of the life process. Paradoxically, the emphasis on death has as its major goal the promotion of mental health among the living.

Conceptually, and in practice, *two major program objectives on death* have emerged:

(1) to inform, educate, and involve mental health workers in activities related to the mental health aspects of SIDS. Projects under this objective include:

(a) formulating guidelines for counseling SIDS families, identifying the needs of surviving siblings, and clarifying the role of the mental health consultant; (b) developing and distributing mental health-related SIDS literature to community mental health centers and other mental health constituencies; (c) conducting model seminars and workshops on the mental health aspects of SIDS for men-

tal health workers; and (d) encouraging community mental health centers to participate in emerging service delivery networks in order to provide a full range of services to surviving SIDS family members.

(2) to develop a primary prevention program focused on parent-child interactions around the crisis of death. This objective encompasses the areas of death, dying, grief, bereavement, needs of surviving parents and children, and death education, including anticipatory guidance about death. Relevant projects to date include:

(a) In cooperation with the National Institute of Child Health and Human Development (NICHD), a research planning workshop was held in May 1975 on the theme "The Impact of Infant Death on Parents and Siblings." Participants explored and identified the research, training, and service needs of surviving family members when an infant dies whether from SIDS, prematurity, congenital malformation, or any other cause; (b) A work conference was convened in July 1975 to focus on two aspects of the theme of parent-child communications about death: (1) promoting death education as a part of parent education, i.e., anticipatory guidance, death as a part of life, and (2) helping parents to help their children understand and deal with death after a loss occurs. Mental health and behavioral specialists in the death area joined with communications experts to develop guidelines, identify priorities, and propose activities and approaches for public education as well as professional training; and (c) Prior NIMH activities in related fields were reviewed to identify the state of existing knowledge and program gaps with particular emphasis on the subject of death-children-families.

For the immediate future, staff effort will be devoted to the two death area objectives stated above. The emphasis on parent-child communications about death will be developed within the context of parent-child interaction in general, with one goal being to increase presently limited visibility and support for parent education efforts at the Federal level. In addition, public education projects will be pursued to promote greater awareness about the characteristics of normal grief reactions as well as some of the harmful cultural myths relating to comforting the bereaved, e.g., "it was only a baby," "don't think about the past," "get pregnant as soon as possible," etc.

Mental health trainers will be encouraged to include content about death and the management of bereavement and grief within clinical training programs. Mental health service programs will be informed about the importance of preventive intervention by reaching out to families with young children when there has been a death in the family, particularly the death of a parent or sibling. Such involvements should lead to the identification of other unmet needs and subsequently to additional program developments.

Some Observations and Principles on Primary Prevention Program Development

The following observations and principles seem to me to be important considerations in the design and implementation of primary prevention activities:

(1) Problem areas which are fundamentally public health matters but having mental health components offer significant opportunities for mental health workers to implement the principles and practices of community mental health, particularly reaching out and collaborating with other community agencies around a specific issue. The continuance of mental health conceptually and operationally as separate and distinct from health deters effective program development.

(2) Mutual-help groups of various types concerned with particular human problems and life crises exist in virtually all communities. Such groups offer opportunities for meaningful assistance to persons in need by others who have had similar experiences. Community mental health workers need to become more aware of and allied with relevant mutual-help groups on an equal status, collaborative basis.

(3) Primary prevention program development should proceed from a base of scientific knowledge, not merely a sense of social action grounded in humanism or do-goodism. For example, mental health workers should be concerned about the quality of housing of the populations residing within the catchment areas of their mental health centers; sufficient rationale for professional involvement prevails in the knowledge that good housing has an effect on mental well-being, that rats breed disease, and that families living in fear of rat bites are not likely to be families with optimal levels of mental health.

(4) Mental health workers have a responsibility to identify and reach out to specific high-risk populations, rather than to wait until representatives of such groups become sufficiently disturbed to appear at a mental health facility, if they present themselves at all. Primary prevention philosophy and practice point to the need for active outreach. For example, recent research has pointed to the imperatives of providing early crisis intervention services to family members who have experienced the death of a loved one, especially when the deceased is the parent of a young child, or when a child dies leaving surviving siblings (Furman 1974). Similarly, research evidence points to an association between loss of a parent during early childhood and the onset of mental illness in adulthood (Beck et al. 1963; Hilgard et al. 1960).

(5) The understanding of death by a child or even an adult can be perceived within the context of achievement or mastery of a

developmental task. Accordingly, community mental health centers could focus their primary prevention efforts on programmatic activities devoted to facilitating achievement of the various developmental tasks of childhood and adulthood. Havighurst (1956) and others have enumerated the developmental tasks through the lifespan, from infancy to old age. A concern with developmental tasks would involve mental health facilities in collaborative efforts with other community agencies sharing similar interests. This particular approach to primary prevention is consistent with our capacities to define, measure, and evaluate a program.

(6) Need exists for a wide variety of primary prevention action programs. Using a crisis theory/intervention model one can enumerate a lengthy laundry list of life crisis points. The particular starting point, that is, the specific problem area and the specific high-risk group, is more a function of local community needs, resources, and priority setting than of predetermined professional procedures.

(7) Primary prevention efforts should always be identified with specificity, e.g., the primary prevention of the pervasive grief/guilt reaction among SIDS parents by provision of information, educational, and counseling services. The target population, the goal, and the forms of intervention should be well-defined and identified. General statements about primary prevention only serve to increase fuzzy thinking.

(8) Systems approaches suggest that "everything is connected to everything else." In this connection, a program, by definition, should be a *planned* effort to approach various aspects of an identified major problem by means of a series of interrelated projects; a single, isolated, one-shot project is not a program. This definition of program connotes a *sustained commitment* consistent with planned social change in order to modify institutions to make them more responsive to community need.

(9) Primary prevention is not the exclusive preserve of mental health consultants and educators. Important roles and functions exist for clinicians in primary prevention programs, especially in crisis intervention approaches.

(10) There is no substitute for a thorough knowledge of the community. This point needs no elaboration since it is the basic element of community mental health practice.

Some Gaps and Problems

Some of the gaps or unmet needs which must be addressed to facilitate the development of primary prevention programs include:

(1) making a commitment at the policy and operating levels to provide support, encouragement, resources, and both a clear sanction and mandate for primary prevention activities

(2) sufficient financing and organizational structures with visible responsibility and authority for primary prevention programs

(3) expanding our knowledge base through new research, particularly explorations into coping methods, effective counseling techniques, optimal educational interventions, and the nature of life crises

(4) providing inservice training opportunities for mental health workers to become more familiar with public health principles and epidemiology

(5) developing training programs in primary prevention content, techniques, and methods for a wide variety of mental health workers

(6) creating a clearinghouse of information on ongoing primary prevention projects

Closing these gaps and resolving the complex issues merit the concern of mental health leaders at all levels.

And, lastly, there are two problems:

(1) The perception of the role and function of mental health workers held both by the general public and by various community care-giving agents seems inconsistent with optimal community mental health practice. The prevailing image of mental health workers is one in which their energies are almost exclusively devoted to providing treatment services, usually of a prolonged type, to "crazy" people. This image becomes a barrier to reaching out and providing services to people experiencing life crises—the very people who would not present themselves at mental health facilities.

My argument is not anti-therapy as much as it is pro-crisis orientation. The common humanity of us all—the problems we each face in dealing with a crisis, particularly the death of a loved one—requires the existence of community mental health facilities capable of being responsive to human need at times of stress; this, too, is what primary prevention is all about!

(2) Related to the image of mental health workers is an organizational dilemma, namely the difficulties in integrating a treatment and a preventive orientation within the same community mental health center. At this relatively early stage in the history of the community mental health center movement, perhaps we lack suitable models for emulation. However, such models must be developed. For too long we have wrestled with the issues of medical model *vs.* nonmedical model. Perhaps the imperatives of primary prevention emerging on society's agenda make it timely for us to raise questions as to whether and how a single facility can house dual, not competing, models under the same auspices.

Resolution of these two problems will result in more effective service delivery systems and many of the modifications needed to

facilitate the conditions necessary for emphasis on primary prevention.

Closing Comments

Viewed within an historical perspective this conference should be memorable. At last, primary prevention has made it to center stage (at least for the next 2 days), and we stand as witnesses to and participants in what may well serve to initiate and stimulate a major turning point in the consideration and determination of priorities in the mental health field, as well as a new awareness, commitment, and rededication to the principles of community mental health.

That we have arrived at this point is to me a tribute to the "giants" of primary prevention, several of whom are here tonight. And I would like to extend a special acknowledgement first to Don Klein, both for his outstanding pioneering in primary prevention with Erich Lindemann at the Wellesley Human Relations Service a facility which dates back to 1948, as well as for a magnificent job in organizing and conducting this conference. Second, I'd like to single out a major mentor who took this then beardless youth in tow in 1961 and proceeded to serve as colleague, role model, and friend—Bill Hollister. And lastly, appreciation is due to Bernie Bloom who has brought exceptional conceptual clarity and research evidence to bear on primary prevention.

Now two closing thoughts.

First, periodically, we need to remind ourselves that our work demands perspective . . . we have opted to be involved in no less than a slow, seemingly evolutionary process of participating in the creation of better, stronger, more competent people and a more humane society—a process which at minimum will take place over a span of generations. Often we will not see the full fruits of our labors, nor will we always know for certain that our particular forms of action or intervention have had the specific effect on populations we had envisioned. Such is the nature of our endeavors and hopes.

And finally, in his presidential address to the American Orthopsychiatric Association in 1962, Leon Eisenberg called for mental health workers to be advocates of prevention and to be responsible for the promotion of social as well as professional action for mental health (Eisenberg 1962). He invoked the words sounded by the sage Hillel 2,000 years ago: "If I am not for myself, who is for me? And if I am for myself (alone), what am I? And if not now, when?"

In closing, I turn to the same ancient writings (*The Ethics of the Fathers* 1957) with the hope that our work in the days ahead will

be productive as well as rewarding so that we all can take direction and inspiration from the words: "It is not thy duty to finish the work, but thou are not at liberty to neglect it."

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BASIC STRATEGIES IN DESIGNING PRIMARY PREVENTION PROGRAMS

by William G. Hollister, M.D.

Imaginative and competent planning of primary prevention programs to be carried out by mental health related staffs requires the use of some organizing schema to guide the program development. In our training experiences, the stress-model strategies that follow have helped many planners to conceptualize the task and to create practical feasible programs.

The first issue that must be dealt with is "What can we prevent?" Humility is the keynote in setting the goals of prevention programs. Someday, we hope, we shall learn how to prevent the major psychoses, neuroses, and the character disorders, but until that day we must settle for more humble objectives. Those of us in psychological fields can wisely borrow from the experience gained in preventing physical disorders. Even in physical medicine the first preventive efforts were not to prevent serious disease processes such as heart disease, cancer, or arthritis; first efforts were to prevent injuries, hemorrhages, debilitation from fever, wound infections, and other disabilities. Instead of rejecting prevention in the mental health field because we cannot yet prevent schizophrenia, let us, as physical medicine has done, start humbly with today's knowledge and gain experience step by step.

What is feasible now? Let's undertake to pursue some simple, direct, modest goals such as preventing:

(a) *specific behaviors* that are self-defeating or harmful to others, such as poor or unhealthy habits, overeating, procrastinating, evasiveness, blaming others, and "setting the stage" to fail
(b) *role failures*, as a student, a parent, or an employee
(c) *relationship breakdowns* between husband and wife, parent and child, boss and employee, including detection and control of interpersonal "games" that are destructive
(d) *feeling over-reactions* such as panics, new situation anxiety, flights, and temper tantrums
(e) *psychological disabilities* such as the social deterioration of

a confined ill person, personality decompensations, "going to pieces," or falling into melancholia instead of experiencing normal grieving

Note immediately that, with such a conceptualization, many of the commonsense services already given in the community by mental health and other helping agencies can be identified and publicly acknowledged as prevention efforts.

The Stress Model

Opportunities to develop preventive interventions become apparent when disabilities of all kinds are conceptualized as products of interactions between stressors (commonly called stresses) having an impact on an individual and evoking a response from that person. This schema assumes that we all live in a field of forces, responding to those forces in ways to survive, to maintain our integrity, and to meet our basic needs by coping with those forces or maintaining a balance (homeostasis) with these stimuli. Interaction with stimuli is essential to our growth, development, productivity, and creativity (Selye 1956).

It is critical in prevention planning to discriminate between those conditions under which forces are stimuli and those conditions under which forces become stressors. One man's stimulus can be another man's stressor. Furthermore, factors such as the intensity, duration, frequency, clustering, and nature of stimuli, as well as the individual's perception of and/or vulnerability to such stimuli, affect whether the stimuli escalate into becoming stressors. Usually stressors are stimuli that may: (a) threaten our survival, (b) threaten our emotional security, (c) defeat our expectations, and/or (d) overwhelm our coping abilities. Stressors also may be stimuli that provoke us into overreaction or underreaction or may induce unhealthy degrees of dependency, clinging, flight, fight, or inappropriate coping. At some times, the individual perceives the threat, the deprivation, or the inadequate response. There are other instances when individuals seem to be unaware of or to deny the harmful impacts of stressors upon them or the inappropriateness of their response.

In planning public service prevention programs, it is important to recognize two major areas of preventive effort:

1. *Clinical Prevention Activities* where prevention of specific behaviors, role failures, relationship breakdowns, overreactions and disabilities are being carried on by clinicians working with individuals or families either before (primary prevention) or after disability has occurred (secondary or tertiary prevention). This work should be supplemented by:

2. *Group Level Prevention Activities* where a blend of educational, consultative, clinical, and social action methods are being used to effect primary prevention (before any difficulty occurs), secondary prevention (halting progression of a disability), or tertiary prevention (prevention of chronic disability or relapse). A key primary prevention planning task in this group level approach is the detection and definition of *target groups* of people: (a) who are exposed to unusual frequency, durations, intensities, clusterings, or kinds of stressors; (b) who may or may not perceive the risk they are running; (c) who, by previous experience, are known to have a high degree of vulnerability or disability when feeling the impact of such stressors; (d) who are accessible; and (e) for whom there is a feasible intervention.

For all such target groups, judgment and eventually research findings will have to be used to ascertain whether the potential casualty rate in the group justifies exposing the whole group to screening and/or the intervention, or whether the intervention will provide sufficient benefit to the whole group (without undue negative impacts or invasion of person) to warrant the program.

The Basic Design Strategies for Primary Prevention

There are four major strategies of primary prevention: stressor management, stressor avoidance, stress resistance building, and stress reaction management. Although these strategies of prevention can be applied to clinical prevention, the focus in the paper is on group level interventions.

Stressor Management

Here the focus is on managing the stressors before they have an impact on the person. Essentially the steps are:

(1) By personal interviews, records analysis, or social analyses, detect and list the stressors having or about to have an impact on the target group. Where possible, gather information on the frequency, duration, intensity, clustering, and nature of the stressors. Usually it helps to list (a) demands, (b) expectations, (c) pressure, and/or (d) conflicts affecting the persons.

(2) Classify the stressors into those that are not changeable and will have to be endured, and those stressors that are potentially changeable.

(3) Group the list of changeable stressors by source: basically those that are (a) external social stresses (impersonal), (b) interpersonal stressors in origin, and (c) self-imposed stressors emanating from an individual's needs, behavior patterns, and internalized group standards.

(4) Identify those stressors that might be decreased, modified, or eliminated. Sometimes it is also helpful to identify stressors which might be altered immediately and stressors which will require long-term efforts.

(5) Design interventions to decrease or modify some or all of the stressors that might create casualties.

Example: We worked with a public school faculty that felt overstressed. In a group meeting they listed over 40 stressors affecting them. Later, in discussion, they judged 14 stressors relatively unchangeable and 26 potentially changeable. After a workshop, they forwarded 10 suggestions to the school administration on cutting down undue demands on themselves. They set up a team to visit the PTA executive board with requests to build into PTA meetings and home-school conferences certain steps to reduce parent-teacher misunderstandings. Interestingly, they concluded that some of their own unrealistic goals and expectations of each other could be modified and eliminated. In short, they set about to lower the total stress load on themselves to prevent future role breakdowns.

Stressor Avoidance

There are situations in which it is relatively impossible to modify or eliminate the stressors operating, but it is possible to get some of the vulnerable persons away from feeling the impact of such stressors. The steps usually are:

(1) Based on clinical experiences, cohort studies, or other date, identify groups or kinds of persons at *high risk* to becoming disabled or adversely affected by stressors that may or are now beginning to have an impact on them. For example, Bower (1962) and others have developed screening tests to detect schoolchildren who are "vulnerables," likely to be learning failures, dropouts, or to have behavior problems if faced with the usual classroom experience.

(2) Identify the settings, situations, or interpersonal encounters where such high-risk or vulnerable persons or groups are exposed.

(3) Set up and plan ways to avoid these vulnerable persons being exposed; arrange to withdraw them from potentially disabling situations or encounters.

Examples: Illustrating this strategy are such commonplace measures as curfew laws to prevent exposure of immature persons to stressors beyond their level of coping, placement services to shift a scapegoated schoolchild into a more supportive classroom, assignment of an employee to a more achievable job, and removal of a child from a "noxious" home.

Stress Resistance Building

In this strategy, the major effort is to mobilize strength-building experiences—strens (Hollister 1967)—that will enable persons in the target group to more readily resist or cope with stressors to which

they are or may be exposed. The basic steps of this approach are:

(1) List the stressors having or about to have an impact on persons in the target group. Then, for each stressor, identify the cognitive understandings, the emotional securities, and the coping skills that might help such persons to withstand and cope with the stressors.

(2) Design a program to gain access to the target group to provide the educational inputs, emotional strength-building experiences, and the social supports identified as potentially helpful. *Anticipatory guidance* is a type of stress-resistance strategy; it involves timing a specific preparatory strength-building intervention to occur just before exposure to an anticipated crisis. Other strategies are long range and less specific in nature, calling for providing the target group with intellectual and emotional growth experiences that enhance their general psychological health and competency to deal with whatever stressors they may face.

Examples: Most mental health-related education programs such as premarriage, parent, and preretirement education seek to lower the negative impacts of responsibilities and provide coping resources prior to a new experience. Group experience workshops that provide experiential learning to build and maintain relationships, to do mutual problemsolving and decisionmaking, or to resolve conflicts or be assertive are efforts to build in cognitive, emotional and social skills to cope with stressors persons may expect to encounter. Organizing self-help groups or mobilizing an emotional and social support network ahead of time helps people endure and survive crises (Caplan 1964).

The selection of the ideas, information, and coping behaviors, the relationship building, problemsolving and decisionmaking skills, as well as identity development, self-image building experiences, and social-emotional growth experiences to effect strengthening of personalities, must still be done on a commonsense basis. Unfortunately, we do not yet have adequate research to establish direct linkages between given interventions and specific preventive outcomes. It is wise to remember that we still advocate and help individuals to use soap, eat wisely, adopt hygienic habits, and exercise to prevent physical illness or disability even though these *general strength-building* activities can rarely be linked to preventing specific diseases. While awaiting definitive research findings, let us proceed, as physical medicine does, to gain experience with general health and competency-building interventions.

Stress Reaction Management

This particular primary prevention strategy overlaps with the field of secondary prevention because it is also used to prevent progression of a disability once the person has already felt the impact of the stressors. Here the focus is on preventing the person's response to stressors from compounding his problems or becoming

more damaging than the impact of the stressors. The analogous model from physical medicine is the process that occurs in many allergies. An external toxin (the stressor) may be relatively mild, but it may provoke such an overwhelming overreaction by the body (fever, redness, pain, edema, and swelling) that persons may die from the effects of an overdefensive body reaction. Similarly, it is common human experience that persons may over- or underreact to mild stressors, thereby turning them into major crises. The major steps of this strategy in working with community groups are:

(1) Detect inappropriate over- or underreactions to stressors that tend to escalate or compound the difficulty or disability that persons experience. Data on such reactions can be gathered by history-taking, observations of group behaviors, or clinical studies of representative members or leaders of the group.

(2) Organize educational, anticipatory guidance or group experiences that can desensitize persons to stressors in order to diminish or modify the inappropriate response. Occasionally, clinical, one-to-one confrontations and work with core persons and leaders of a group can effect changes in behaviors which set a new model for an entire group. This approach resembles the practice of training and selecting military combat leaders for the "cool" behavioral model they set for their men when under fire, or casework with the mother or other "strong person" of a disorganized family.

Examples: Knowing the tendency of groups to panic, fire and evacuation drills have been used to establish a planned coping response to danger. Orientation experiences are used to decrease new-situation anxiety in youth coming into a new school experience or persons entering a new job or role. Groups can be desensitized to fear-inducing stressors by (1) periodic small doses of an experience to engender increased coping skills (immunization approach), (2) anticipatory guidance education to prepare for crises, (3) behavior modification, or (4) relaxation training methods. Mobilization of socioemotional support networks for persons in crises as well as for vulnerables susceptible to making inappropriate responses to stresses (i.e., a wavering Alcoholics Anonymous member) also may lower nonadaptive responses. Setting up grievance mechanisms to channel the anger accumulating in groups and the use of family or group "motivation-tapping and goal-setting" experience to break apathetic responses illustrate useful group process tools.

Summary

Disciplined surveys of target groups in the community which operate under heavy pressure will reveal a number of possible high-

risk casualty groups or vulnerables needing protection, such as the poor, one-parent families, the unemployed, families of the mentally ill, and mothers of the mentally retarded. Through service contacts, records, and interviews, it is feasible to ascertain the demands, expectations, conflicts, and pressures that are their stressors. The same data sources may also yield information on the adequacy of their resources to cope or endure the field of forces having an impact on them.

Whether the programs designed to prevent the casualties utilize a clinical approach to individuals or families, or a group approach to a sector of the population at risk, primary prevention program planners have the choice of using and blending approaches which (a) diminish, modify, or eliminate the stressors, i.e., stressor analysis and management; (b) remove vulnerables from exposure to stressors, i.e., stressor avoidance; (c) build up individual or group capacity to withstand stressors, i.e., stress resistance building; or (d) decrease inappropriate reactions to stressors, i.e., stress reaction management.

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EVALUATING ACHIEVABLE OBJECTIVES FOR PRIMARY PREVENTION*

Bernard L. Bloom, Ph.D., M.S. Hyg.

An emphasis on the prevention of emotional disorders is one of the most important distinguishing features of the community mental health movement. Before discussing the topic of primary prevention program evaluation, a review of those attributes which serve to distinguish the field of community mental health seems appropriate.

As the term suggests, community mental health refers to all activities undertaken in the community in the name of mental health. Thus, the first dimension on which community mental health can be distinguished from more traditional clinically oriented activities is its emphasis on practice in the community as opposed to practice in institutional settings. The other aspects of community mental health are less clear from its title, but in each case they can be distinguished from more traditional clinically oriented practice. A second dimension is its emphasis on a total community or total defined population rather than on individual patients considered singly. The phrase "catchment area" has been commonly used to describe the population that can be thought of as the legitimate concern of a community mental health program. A third dimension is its emphasis on preventive services as distinguished from therapeutic services. These second and third distinguishing features of the community mental health orientation can be viewed together as the application of public health concepts to the field of psychopathology. A fourth characteristic is its emphasis on comprehensiveness and continuity of services. A community mental health program should be a system of services with easy flow between its component parts. In addition, a program should meet the full spectrum of mental health-related needs in the community. A fifth

*This paper is a revised and enlarged version of the presentation delivered at the Pilot Conference. This revision draws on material previously written by Dr. Bloom and published by the University of Wisconsin Press: *Comprehensive Mental Health: The Challenge of Evaluation*. L.M. Roberts, N.S. Greenfield, and M.H. Miller, eds., 1968, pp. 117-135. Permission to use the material is gratefully acknowledged.

characteristic of community mental health practice is its emphasis on indirect services rather than direct services. The clearest examples of indirect services are consultation—in which a mental health professional attempts to make a significant intervention in the lives of a group of people by working with primary caretakers who have access to larger social systems such as teachers, clergymen, or public health nurses rather than directly with that system's clientele, and mental health education—in which mental health professionals, often through the mass media, attempt to reach large but undefined numbers of people in order to have a positive effect on their psychological adjustment.

A sixth characteristic is its emphasis on innovative clinical strategies that have the potential for meeting the mental health needs of larger numbers of people more promptly than has ordinarily been possible. Of all the innovative approaches that have been attempted, the most common include brief psychotherapy and crisis intervention. A seventh characteristic of the community mental health orientation is its emphasis on a rational planning process in decision-making regarding mental health programs. Such planning often includes demographic analyses of the community being served, the specification of unmet mental health needs, the identification of populations within the community who are at special high risk of developing those kinds of disorders identified as mental illness, the coordination of mental health services in a community, and the establishment of priorities within a community for dealing with problems directly or indirectly related to emotional unrest. An eighth characteristic of the community mental health orientation is its innovative use of new sources of manpower. Rather than viewing appropriate sources of manpower as limited to the traditional professions of psychiatry, social work, psychiatric nursing, and clinical psychology, the community mental health professional seeks to create new sources of manpower, and such terms as the "paraprofessional" or the "indigenous mental health worker" have been coined to describe these colleagues who work with him in the community mental health center.

A ninth characteristic of the community mental health movement is its commitment to what is usually called community control or community involvement—the belief that the mental health professional is not the sole source of data as to the mental health-related needs of the community or the best ways to meet these needs. Rather, the staff of a community mental health center should join with the community or its representives to identify needs, propose and evaluate programs to meet these needs, and plan for future program development. The concept of community control suggests that a community mental health center operates in behalf of the community it serves. A final characteristic of the

community mental health center orientation is its interest in identifying sources of stress within the community, that is, in thinking of the community as having certain counterproductive stress-inducing properties, rather than assuming that psychopathology is exclusively within the skin of the identified individual patient.

There is an implied criticism of traditional mental health activities in each of these distinctions. It has been the view of many mental health professionals that traditional mental health services:

- have been inappropriately divorced from the communities in which patients have lived
- have been concerned too much with those individuals who find their way to the clinician, to the exclusion of developing a broader concern for a population
- have been almost exclusively focused on the treatment of psychopathology without devoting adequate resources to activities that might prevent certain forms of psychopathology from occurring
- have failed to provide an organized system of services or services which in their totality meet the mental health-related needs of the community
- in their emphasis on direct patient services have neglected to develop their skills in enabling mediating caretaking agencies and persons to work more effectively with their clients
- have placed too much emphasis on long-term individual therapy to the exclusion of therapeutic strategies that might be helpful to greater numbers of patients
- have developed without adequate coordination with other existing services
- have not made adequate use of nontraditional sources of manpower
- have largely ignored the community in developing mental health services
- in their failure to identify those community characteristics that appear to enhance or inhibit growth and development, have been engaged in an inefficient and perhaps irresponsible allocation of their limited resources

With this background reminder, we can approach the subject of evaluation. The factors which conspire to make the task of any form of mental health program evaluation a nightmare are well enough known to warrant but a one-sentence summarization. We are generally asked to evaluate the outcome of an undefined program having unspecified objectives on an often vaguely delineated recipient group whose level or variety of pathology is virtually impossible to assess, either before or after their exposure to the program.

The task of program evaluation is essentially one of answering

the following question: How much success is achieved by a particular program in accomplishing a predetermined set of objectives? The case of a primary prevention program is but a specific example of the general question: How much success is achieved by this specific primary prevention program in accomplishing its predetermined set of objectives?

First, it should be noted that both the program and its objectives are to be specified in advance. Generally the description of a program is not difficult, but the description of a program's objectives is often unbelievably complex. Any mental health program rarely has but a single objective; yet, in the mental health field the notion of a variety of objectives arranged in some hierarchical organization is not generally acknowledged. For example, many new mental health programs have as their chief objective, just as do new human beings, sheer survival. The program is publicized, and efforts are made to ensure and expand staff, community visibility, and power. Yet, because the objective of program survival rarely has public legitimacy, such efforts often have to be bootlegged and disguised in annual reports as community education or entered under the ubiquitous category "other." But the fact that there are multiple objectives of varying degrees of importance is only part of the problem. An agency may have its corporate programmatic objectives, and the staff may have their personal objectives. There may be short-term objectives which are quite different from long-term objectives. Objectives may differ in degree of rationality yet be equally important in determining program activities. Some objectives may be antagonistic to each other; achieving one may mean that another cannot be achieved. There may be a set of public objectives and quite another set of private objectives. And the degree of awareness of the whole array of program objectives is often highly variable, depending on the particular person as well as the particular objective.

With primary prevention programs it is rare that the only objective is the reduction in the incidence of a particular disorder, even though this may be the ultimate objective. A whole series of intermediate objectives usually need to be achieved on the way. In one community it may become clear that in order for a primary prevention program to succeed it will require a major reorganization of the existing health and welfare agency network. The accomplishment of this objective is crucial, and evaluation procedures need to be developed to determine the extent to which it has been attained. In many communities, successful primary prevention programs require a significant change in interagency communication patterns. The accomplishment of this goal is a legitimate program objective. Changed agency attitudes toward certain clientele are often a necessary program objective, yet rarely recognized or evaluated. The

legitimacy of personal needs, for example, job satisfaction, high morale, or community status, has to be recognized. In the mental health field, one of the more interesting areas requiring empirical study is the development of a taxonomy of program objectives, perhaps by the exploration and analysis of the objectives of a carefully selected sample of service agencies. Such a study, long overdue, would not only yield useful results in its own right but also would be likely to have as a byproduct the legitimizing of some objectives not now so considered.

A second aspect of our evaluation question is the fact that evidence must be presented to show that the program is the cause of the change in the recipient group, if a change can be demonstrated. Ordinarily, some form of control or comparison group design should be utilized in attempting to demonstrate program effectiveness. The need for a control or comparison group is directly related to the established validity of the treatment technique. If it can be shown that the application of a particular technique leads toward the attainment of a specified objective, then evaluation efforts need deal only with the extent to which the technique is being applied. This would be true, for example, of the use of seatbelts as a technique for reducing automobile accident fatalities. In this instance, the cause-effect relationship has been reasonably established, and one need concentrate primarily on increasing the application of the technique. If the relation between the application of the technique and the attainment of the objectives has not been adequately demonstrated, as is the case in most aspects of community as well as institutional mental health programs, major effort has to be directed toward this demonstration. It is of small consequence to show the extent to which a particular treatment is being provided when the validity of the treatment in attaining the program objectives has not been established. While an ideal study would start with matched samples, in which one group would be the recipient and the others would receive no service or different services, such a design is quite difficult to execute. In primary prevention programs, it would require matched communities far enough apart geographically so that the program instituted in one community would not spill over into the other. In addition, a sufficient degree of population stability would be required in both communities so that one could count on an adequate time interval to provide the program and to study its consequences. Short of a matched group design, some form of comparison over time should be undertaken, even though such longitudinal studies always leave open the possibility that observed changes might have occurred without the program. If large enough samples from the receipient group are drawn at frequent enough intervals, and if one knows in advance exactly what one is looking for to determine program effectiveness, it should be

possible to make the study of time trends quite productive.

A third aspect of the evaluation question is the determination of the amount of success. This determination first requires the conversion of statements about program objectives into observable and measurable criteria. It has already been suggested that it is easy to overlook important program objectives. It is equally easy to fail to identify variables or methods by which the degree of attainment of program objectives can be estimated. Evaluation studies can be categorized according to where one looks for evidence of program success and the kind of collected information upon which judgments of success are based. One common type of evaluation reported in the literature is one which more appropriately should be called program description. These studies present a narrative account of a program, often of its history as well as its current functioning. In a sense, program description constitutes a necessary introduction to a program evaluation, but it cannot substitute for a program evaluation.

While this paper tends to focus on the consequences of conducting evaluations too late, if at all, a program evaluation can also be undertaken prematurely. A certain degree of program stability is required before the program can be appropriately evaluated. During the early history of any new program, whether it be a community consultation service or a new psychiatric inpatient facility, a carefully developed narrative account of its vicissitudes is not only highly desirable but also may be far more appropriate than a study of its effectiveness. Yet the director of a new program rarely allocates adequate time to the task of describing and documenting its rapidly shifting characteristics and organizational crises. It is from just such a narrative account that much could be learned which would be of use to others planning similar programs elsewhere. A program diary has all the usefulness of a personal diary. It can capture the day-by-day stresses, the reactions, and the counterreactions in a manner which no retrospective study could hope to do. Events often move so quickly and in such a complex manner that it is unlikely that these issues could be validly described if one should wait a year or longer to review one's organizational history.

In some cases there is considerable question as to whether program stability can be achieved or whether a program inaugurated as a trial can achieve permanence. In these cases, a carefully prepared narrative account is especially useful. While it is always hard to deny the urgency of the clinical needs which lead to the establishment of many programs, administrators might do well to consider seriously the long-term deleterious consequences of allocating virtually total staff time to service with little, if any, to systematic program description.

While the need for a program description is indeed great, it is well

to remember that a program described is not a program evaluated. In most cases, a subsequent evaluation, a study of effectiveness in meeting predetermined mental health program objectives, is appropriate and desirable.

A second type of evaluation is based upon judgments made about a particular mental health program by the recipients. These are the studies which report that a certain percentage of patients state that they feel better after receiving treatment at a clinic, or a certain percentage of public school teachers report that they can deal with problem pupils more adequately now that they are receiving regular weekly group mental health consultation. While such reports are important, the problems in their interpretation are manifold. There is the difficulty in distinguishing between the valid report and the one given because it is expected. Assuming the validity of the report, there is the problem of determining to what extent the existence of this specific program is responsible for the report. Such a determination may require the parallel study of a comparison group not receiving consultation. Assuming both the validity of the report and the fact that it is the participation in the program which resulted in the report, one must then determine the report's significance. Since it is not often that an improved self-report is the major goal of a mental health program, the question must be raised as to whether a report of increased effectiveness has any demonstrable parallel in behavior. Does a teacher who reports that she is doing better with her hard-to-manage pupils actually behave any differently toward them than she formerly did? If no significant behavior difference can be demonstrated, how is the importance of the report to be determined? In many ways, therefore, an evaluation of a primary prevention program which bases its method upon the analysis of judgments made by recipients of service poses especially difficult problems in interpretation.

A third type of evaluation is based upon judgments of program effectiveness made by the providers of the service or by outside professional experts. Included in this group of studies is the time-honored use of clinical judgment. The valid use of professional judgment in assessing program effectiveness requires: first, some indication of the objective evidence which forms the basis of the judgment and, second, some indication of interjudge and interjudgment reliability. The requirement of objective evidence means, in effect, that a method is provided whereby a judgment can be made by someone not directly involved in providing the service. This requirement also establishes the feasibility of studying outcome by contrasting treated and untreated groups, since judgments of outcome can be made independently of knowledge as to whether treatment has been provided. The study of judgment reliability is not only methodologically important, but it is also important because when

the reliability of clinical judgment is assessed, it is often disappointingly low. Nor does the practice of pooling clinical judgments to arrive at a consensus solve the reliability problem. The problem must be dealt with at the level of the instrument used to measure outcome, in this case, the clinical judgment itself. What is its reliability? If it is low, that is, if there is interjudge or interjudgment disagreement, what factors account for it? What would be the significance of the finding that professional judgment does not agree with the judgment made by the recipient of the service? A low measure of reliability sometimes signifies that judges use different sets of objective data on which to base their judgments. Is there satisfactory agreement on the presence or absence of bits of objective data, regardless of whether this information is employed in making the clinical judgment? What objective data should be searched in order to make a clinical assessment of outcome in each particular program?

It may be comforting to keep in mind that problems of reliability of diagnosis and determination of treatment outcome are nearly as common in general medical practice as in the psychiatric specialties. Studies have shown wide interjudge variability in diagnosing malignancy from tissue slides and in identifying and interpreting heart abnormalities with a stethoscope. The physician is as troubled about definitions of physical health and illnesses as are mental health professionals regarding the definitions of mental health and illnesses. Mental health professionals are distressed at how few of their most commonly used treatment procedures have been adequately evaluated. Yet in spite of their frequent use, a definitive evaluation has never been reported, for example, of surgical removal as treatment for breast cancer or of typhoid or diphtheria immunization, and agreement has not yet been reached as to the value of the recommended annual physical examination.

A final type of program evaluation which has been identified in published literature is based upon an analysis of objective community data without recourse to any intervening interpretive judgments. A community mental health center program is successful if the first-admission rate to the nearby State mental hospital decreases. A State mental hospital program is effective if the length of hospitalization and readmission rate both decline. A consultative service to juvenile court is successful if the recidivism rate decreases, and so on. Since these kinds of data often bear directly on primary objectives, and since interpretation does not rest so heavily upon required concurrent studies of reliability, this type of evaluation seems to present fewer methodological problems and greater potential usefulness than those previously described. The major consideration in undertaking an evaluation study of this type is to ensure wise choices in the selection of community variables to be measured.

These variables must, of course, be amenable to measurement and must at the same time have direct pertinence to program objectives. If such variables can be identified, program evaluations of this type have some obvious advantages over those discussed earlier.

No program administrator hearing these general remarks about evaluation can fail to be impressed by the fact that evaluation costs money and time. Somewhere between 5 and 10 percent of every mental health agency's budget should be allotted to research; and program evaluation should constitute a significant portion of the research effort. We simply have no choice but to undertake continuous evaluations of our efforts; and we never have had such a choice, even though most mental health programs act as if we do. Imagine for a moment a community-based program of water purification—with a full staff of local purifiers, all busy introducing assorted, partially identified substances into some of the sources of the public water supply, with a prestigious staff of consultant purifiers at the State level providing inservice training for the local purifiers, as well as the other services that State consultants can furnish, and even with a Federal grant-in-aid for water purification complete with 2-year plans, Federal consultants, and annual meetings in Washington—in which sources of water are never fully mapped, in which causes of impurity are never isolated, in which techniques for determining acceptable water characteristics have never been established, and in which attempts are rarely made to ascertain changes in water purity as a consequence of our chemical ministrations. I believe this caricature quite aptly describes our activities in the field of mental illness prevention.

The foregoing considerations suggest that it might be helpful to mental health program directors and their staffs to review the following questions in the process of developing or enlarging upon mental health-primary prevention, program-evaluation activities:

(1) Do you have an adequate understanding of the demographic characteristics of the population eligible for your primary prevention program and of the community resources currently available?

(2) Do you know what significant differences exist between the group eligible for your program and the group receiving your program?

(3) Do you have a clear definition of your program so that you can reliably group individual recipients or agencies according to the services they received?

(4) Do you have a clear definition of the characteristics of agencies or of individuals your program is designed to influence so that you can reliably group recipients according to these characteristics?

(5) Do you know, from a theoretical point of view, in what manner each of the elements of your program is supposed to influence each of the characteristics you are attempting to change?

(6) Have you assessed the current evidence regarding the effectiveness of your techniques in influencing the characteristics with which you are dealing?

(7) Do you contrast the results of your services by comparing your recipient groups with suitably matched groups not receiving the prevention program?

(8) Are objectives, or goals, established for each recipient or each agency as well as for your program as a whole?

(9) Have you reviewed your statement of program objectives recently to see if it reflects your current program emphasis?

(10) Have you and your staff discussed and labeled those objectives which are not directly concerned with prevention, that is, those objectives which bear on organizational maintenance and related areas?

(11) Have you selected criteria and indexes for the assessment of each of your program objectives?

(12) Can the extent to which you are attaining your program objectives be reliably judged?

(13) If clinical judgment is utilized to study recipient-group characteristics or progress, whether by using formal rating instruments or not, is the reliability and validity of these judgments effectively explored?

(14) Do you make systematic followup studies to evaluate the duration of changes in your recipient groups?

Crothers commented 40 years ago that as far as he knew, there was

> no agreement among psychiatrists as to the value of any current methods of management which justifies that 'mental disease' as an entity is preventable. From every medical point of view, there is every reason to refuse to make any such statement. Definitions are too controversial, the causes of mental disorders are too complex and the time from the presumed preventive measure to the end of the life of the individual is too long for scientific proof of the efficacy of a given method to be easily and quickly established (1937, p. 72).

The limited progress which has been made in the last quarter of a century may be assessed by noting that in commenting on some of the practical problems in evaluating mental health activities, MacMahon and his colleagues have cautioned that it is unusually difficult to identify

> a characteristic (whether of people or of communities) that can be shown to change under the influence of a mental health program. From this difficulty it is inferred that our problem is one of identifying a 'satisfactory' method of evaluation. We should not, however, overlook the alternative explanation—that the evaluation is in fact satisfactory but that there is no appreciable change to identify (1961, p. 966).

In addition, however, they have pointed out that because of prior experiences in program evaluation in many fields of medicine, mental health programs may now be in an unusually advantageous position to be evaluated. Critical evaluation is a recognized part of medical thought today. Professional, technical, and financial help necessary to conduct evaluation studies may still be available and, because of the shortage of facilities to provide for everyone in need, the ethical problem of identifying and studying an untreated comparison group does not arise.

While mental health professionals would not subscribe to the view that mental health programs have not resulted in any significant change in either people or communities, they must accept the burden of proof. In this task there is hardly any satisfactory substitute for clinically and scientifically meaningful continuing evaluation of our mental health program efforts.

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Chapter IV

WORKSHOP SUMMARY STATEMENTS

This chapter contains summary statements about the three sets of workshops; each set was comprised of four concurrent workshops. The statements were prepared by the resource persons and made available in advance to conferees to enable them to select their choices.

The theme of the first set of workshops was *Primary Prevention for Specific Target Groups*; the statements address programs dealing with newborn infants at high risk, school age children, widows, and preschool children. The second set of workshops concentrated on the topic *Agency Strategies for Primary Prevention*; specific workshops were held on: (1) the use of epidemiology for program development, (2) primary prevention programming with disadvantaged community groups, (3) cultivation of personal and leadership skills among citizens within a catchment area, and (4) developing programs in collaboration with major community institutions. The third set of workshops concerned *Aspects of Prevention* such as involvement of community groups, program evaluation, management and staffing, and funding.

A. PRIMARY PREVENTION FOR SPECIFIC TARGET GROUPS

PRIMARY PREVENTION PROGRAM FOR NEWBORN INFANTS AT HIGH RISK FOR EMOTIONAL DISORDER

Elsie R. Broussard, M.D., Dr. P.H.

Background Information

In 1963, Dr. Broussard began a prospective longitudinal study of 318 normal, full-term, first-born infants, born in five Pittsburgh hospitals during a specified 2½-month time period. All were single births. Selecting this population ensured that infants were within the range of normal endowment, so that the infant was biologically equipped to elicit response from the mother and not handicapped in his ability to respond to maternal care.

Using the mother's concept of the average baby as an anchor for comparison of her own infant's behavior, Dr. Broussard designed the *Neonatal Perception Inventory* (NPI). The NPI represents a measurement of the mother's perception of her neonate and the score represents the discrepancy between the mother's perception of the "average" infant and her own infant. These inventories were administered to the mothers on the first or second postpartum day and again when the infants were 1 month old. The 61 percent of the infants who were rated better than average by their mothers at 1 month of age were considered at low risk for the subsequent development of emotional disorder. The 39 percent of the infants not rated as better than average by their mothers were considered at high risk. The NPI was found to have both construct and criterion validity.

The hypothesis that *the mother's perception of her neonate was associated with subsequent emotional development* was confirmed

when 120 of the original population of first-borns were evaluated at 4½ years of age by two child psychiatrists who had no knowledge of the children's predictive risk ratings. Infants predicted to be at high risk at 1 month of age had more emotional disorder at age 4½ then those who were at low risk (statistically significant at $P<.001$). Again, when these children were between 10 and 11 years of age, 104 were evaluated by one of three psychiatrists who had no knowledge of the child's predictive risk rating at 1 month or of the previous evaluation conducted at age 4½. Again, there was a statistically significant association ($<.05$) between the predictive risk rating at 1 month of age and the child's emotional development at age 10/11 years, indicating that the NPI continued to be predictive of psychopathology.

Preventive-Intervention Program — 1973 First-Borns

The Pittsburgh First-Born Preventive-Intervention Program was designed to provide intervention for infants at high risk. Included in the project were 281 healthy, first-born infants delivered at Magee Womens Hospital. Their families reside in Allegheny, Butler, Westmoreland, Washington, and Beaver Counties. All socioeconomic and racial groups were included.

Based on the Broussard Neonatal Perception Inventory, 205 infants were placed into a low-risk group at 1 month of age and 76 were placed into a high-risk group at 1 month of age. Using a random method, the high-risk group was divided into 39 for whom intervention was offered and 37 to whom no intervention was offered. Of these 39 to whom intervention was offered, 17 mothers and infants have been involved in the intervention program contacts. These consist of individual interviews with both parents or mother alone, participation in mother-infant groups, and home visits. Prior to beginning the intervention, each of the families is carefully evaluated and a program is designed which is specific for the unique needs of the infant and its human partners. The mother-infant groups have met every 2 weeks since the infants were approximately 2½ to 3 months old, and the periodic home visits have been made on an individualized basis according to our assessment of need of the group participant, generally on a weekly or biweekly basis.

Dr. Broussard's experience indicates that there are observable differences between mothers whose infants are at low risk and mothers whose infants are at high risk. Mothers of high-risk infants are less able to anticipate, assess, and fulfill the child's needs. In addition, the mother's responses to the child's distress appear limited and they are often "locked in" to unvarying devices for soothing the

child. In contrast, mothers of infants at low risk have the ability to use a variety of techniques to comfort the child. Mothers of high-risk infants have difficulty in perceiving danger or threats to the child, so that they are often unable to adequately protect the child in an age-appropriate way.

Clinical observations within the Pittsburgh First-Born Program indicate that the Neonatal Perception Inventory taps the mother's unconscious fantasies so that an indicator of infants at high or low risk is produced. The mother's early perception of her newborn seems to reflect her self-esteem which in mothers of infants at high risk is compromised and secondarily precipitates undue dependence on the external world. The mothers are lacking in confidence in themselves as mothers and are very vulnerable to criticism.

Technique of Preventive Intervention

The program has utilized the specific technique of supplementary parenting through mother-infant group meetings plus home visitation. Supplementary parenting leaves the child's relationship with the primary mother intact, supplementing for the child what the mother cannot be now. At the same time, it gives an opportunity for helping the mother with her depression and her low self-esteem. During the initial process of engagement of the high-risk mothers in the group intervention program, the staff exerts considerable care to avoid presenting themselves as the experts who are competent. Rather, they are supportive of the mother's efforts, encouraging them to find "solutions" within the group and within themselves, having empathy with their struggles, and praising their successes. Great restraint on the part of the staff is required to avoid the urgency of attempting to modify the mother's behavior which would serve to fit in with her low self-esteem—that there is something to be corrected in the child or in the self. The consistency of the empathy of the staff serves as a "different model" for the mothers, i.e., noncritical and noncompetitive. Mothers must first learn to trust the staff before they can learn from them. Growth in the mothers and infants seems to occur through the provision of a new invested relationship which provides an opportunity for identification with the group leaders. In order to help, it is essential to be perceptive and aware not of just where the child is but where the parent is developmentally. It is necessary to identify the nature of the gaps in the parent's own experiences with being parented; then assistance can be provided in these areas.

The group has evolved as a surrogate extended family system. Friendships develop between the mothers, and there are telephone contacts, shared transportation to and from the meetings, and occasional visits to each other's homes.

The group provided them with a multitude of "mirrors," each slightly different from the other and which reflected back to the individual mother a perception of herself slightly different from her own. In this fashion, the differences between the mother's self-perception plus the other mothers' perception of them can create an emotional distancing plus objectivity, whereby the mother can question the appropriateness of her own poor self-esteem and mobilize her progressive mothering wishes. One goal is to give the mother a new image of a potential relationship through the staff's parenting of the mother. As she feels herself valued and respected and her child valued and respected, she can then begin to modify her self-perception and her perception of the child.

Preliminary Evaluation

Eighty-four of the infants were evaluated at approximately 1 year of age at the research facilities by an observer who had no knowledge of the risk rating of the children. These included 34 low-risk and 50 high-risk infants (16 Intervention, 14 Intervention-Refused, and 20 Comparison subjects). A statistically significant difference ($P<.05$) was evident between high- and low-risk infants, with the low-risk having more optimal scores on four clinical clusters: Attachment, Separation Indicators, Aggression, and Implementation of Contact with the Nonhuman Environment.

Examination of the rank order of the mean scores of the low-risk and the Intervention, Intervention-Refused, and Comparison groups showed a trend in the expected direction. That is, the low-risk had the more optimal scores, the Comparison group had the more deviant scores, with the Intervention and Intervention-Refused falling in between these two. The difference between the scores was not statistically significant; however, the fact that the trend was in the expected direction indicates that, although pathology at age 1 had not been totally prevented by the intervention, the mean scores of the Intervention group were closer to the low-risk group who were developing optimally than were the Comparison group to whom no intervention had been offered.

Dr. Broussard reported that 75 of the children had been evaluated again at age 2½. The data analysis has not been completed. Clinical impressions indicate that the Intervention group had continued to progress toward more optimal development whereas the Nonintervened group had less progression toward normality and, in some instances, actual regression.

Special Considerations

It is important to note that the program of intervention was not designed for infants already identified as patients in need of help by the parents or referred by an agency. This unique feature of reaching out to infants judged at high risk during the first month of life influenced the design and procedure of the program.

It is not feasible to tell parents of a healthy, first-born infant that the infant is considered at high risk for subsequent emotional difficulty. This might well exert a self-fulfilling prophecy, i.e., the mother's initial negative perception of her newborn would be compounded by the prediction. In addition, this would fail to take into account that there are a multiplicity of life variables with impact on development which may modify the effect of the negative maternal perception, such as the presence of other family members, various support systems, or some unique capacity within the infant.

The Neonatal Perception Inventory is a research instrument which measures the mother's perception of her infant during the first month of life. When the Inventory is used as a predictive instrument to identify a population of infants at high risk, it should be considered as a *screening instrument*. The use of a screening instrument is the first step which alerts us to potential pathology. The second step is a careful assessment of the functioning of the infant and family to determine if intervention is needed; then the nature of the intervention can be planned.

Implications of This Work for Primary Prevention

The mother's perception of the infant during the first month of life was associated with the child's later development; therefore, it is highly desirable to develop programs which will have an impact on that perception. Another important finding of this work is that the early maternal perception of the infant is in a fluid state which can change during the first month of life. This means that the time immediately after birth is a critical time during which mothers need support and guidance, yet this is exactly the time when the present system of care often does not provide professional support for new parents. Following discharge from the hospital the next "routine" contact does not occur until 4 to 6 weeks later, at the time of the first checkup.

Dr. Broussard pointed to her own previous work of providing televised guidance to mothers during the immediate postpartum hospital stay. Televised guidance was shown to some mothers and not to others. The mother's perception was measured prior to the

showing of the television and again at 1 month of age. Among those mothers who had seen the televised counseling, there was a statistically significant increase in the number of mothers who had a positive perception of their infants at 1 month. This was not true among the population of mothers who had not viewed the television. These findings appear to indicate that an intervention program which could modify the mother's perception of her newborn in a positive manner prior to 1 month of age could have a significant impact on the subsequent development of the child.

Dr. Broussard cautioned that preventive intervention is not easy and requires personnel who have a sound understanding of child development and parenthood. She pointed out that despite the infant's normal biological endowment as judged by professional assessors, the woman whose early experience has not supported the development of a healthy self-esteem within herself seems to view the infant produced by herself as defective, as she feels defective. The mirroring of the mother's negative perception of what she has created and her inability to gratify the child's needs seem to foster the development of another generation with emotional difficulty. She concluded that early preventive intervention with mothers and infants is a must if we hope to modify the generational transmission of emotional disorder. She had no doubt that the place to begin in the interruption of this cycle of generational transmission is with the mothers of the existing generation.

PREVENTIVE OUTCOMES OF AFFECTIVE EDUCATION WITH SCHOOL AGE CHILDREN: An Epidemiologic Followup of the Kansas City School Behavior Project

Wynona S. Hartley, Ph.D.

Problem Definition

The impetus for the Kansas City School Behavior Project derived from difficulties posed for the schools by children who did not function successfully or satisfactorily with their fellow pupils. Efforts to solve these problems through clinical service arrangements had proven inadequate to the need. A committee composed of representatives of the Kansas City School District, the Greater Kansas City Mental Health Foundation, and the School of Education at the University met to explore the nature of the problem, assess needs, and develop ideas for action programs. The committee developed a primary prevention strategy which would deal with existing problems and prevent the development of serious behavioral disturbances in future years. This work culminated in an action-research proposal to NIMH.

The program was initiated by Homer Wadsworth, then president of the school board, who asked the newly formed mental health foundation if some real prevention could be done, instead of just talked about. He offered a $25,000 seed-money grant for the purpose. The Foundation director, Dr. Robert Barnes, accepted the challenge. Dr. William Hollister, of NIMH, was active in the early planning process.

Goals and Objectives

The Kansas City School Behavior project was an experiment intended to enhance the social-emotional development of individual

pupils. The program was expected to treat mild behavioral disturbances in children in the school setting, to prevent severe behavioral disturbances among these children in the adolescent years, and to have this effect in the total community as well as in the school setting. The design was to be executed within the resources of the personnel and time budget of the regular school system, utilizing the teachers in their roles as group leaders. People in Kansas City felt that any long-range solution would require extensive effort on the prevention of behavioral problems rather than on treatment after the problem became serious. Such efforts were to be directed toward the development of classroom methods and techniques in which teachers could be trained. These methods and techniques were intended to produce learning conditions which would be more emotionally healthful for all children in the classroom.

Intervention

Teachers in the experiment were regular sixth grade teachers in the Kansas City school system. Sixty teachers were selected from a pool of 90 volunteers and divided into an experimental and a control group. The teachers in the experimental group received summer training in the methods and techniques of small-group interaction and were given support throughout the experimental school year by project staff directed toward assisting the teachers in their efforts to implement the new approach in the classroom.

A multidisciplinary approach was used, derived from concepts in educational sociology, group dynamics, psychology, and psychotherapy. The exploration of feelings, the use of small groups as a vehicle for social and academic motivation, and the recognition of and dealing with social system and social class differences were three central themes in the training program. The teacher was taught to relinquish her authoritative position and to become a resource person and group member.

The 2-week summer workshop, primarily training in small group techniques, included daily problem-oriented sessions. After the workshop, teachers met as small groups with project staff once a week throughout the school year, discussing problems and techniques of implementation. Advanced seminars were offered the following year by popular demand.

The children said school was more fun, that they had more opportunities for verbal interaction, and that they had a better understanding of themselves and others. Peer support was valued highly, as well as opportunities to lead and to be open. Behavior of disruptive pupils improved, as did that of the withdrawn. Appropriate flexibility seemed to be the general outcome for all of the children.

Implementation

In terms of the effort involved for teachers, school administrators, and students, the program is well within the reach of any school system. Teacher training and support for the schools at all levels could be accomplished through community mental health centers. The intervention process can be used very effectively without any significant expenditure of funds.

Evaluation and Results

The Kansas City School Behavior project was intended to devise and test the effectiveness of a program of action for primary prevention. Early data indicated there might be positive results for one segment of the pupil population 3 years after the experiment took place. This pattern of differences was observed in referrals, suspensions, absence rates, and teacher ratings.

We proposed an epidemiologic followup to answer our questions about the outcome of the project. The strategy for the analysis was: (1) to test again for positive or negative outcome, with emphasis on the ninth grade year, but also checking for earlier findings which might tie outcome more closely to intervention; (2) to test whether the apparent ninth grade year finding could be shown to persist into the following 2 grade years; (3) to test whether this apparent prevention effect could be buttressed with data from outside the school system, giving it both greater credence and value; and (4) to attempt to specify epidemiologic conditions under which the prevention effect was valid or invalid, or was more or less pronounced. If the data produced answers in these areas, we felt we could reasonably make recommendations for the design of future intervention efforts for the health of children and youth consistent with our findings and our understanding of the relationships among the important factors delineated in our analysis.

Our attempt to answer these questions required data collection: (1) of absence rates, teacher ratings, and family file referrals for behavior problems for 2 further school years, extending the time of the followup to 5 years, or the 11th grade year; and (2) police records and juvenile court records for the entire life of each child in the socioeconomic cohort up to and including the 11th grade year. Many other indicators might have been used. Our concern was that we duplicate the earlier data on a longer time line and that we utilize real-life variables: records which are kept as an ordinary process, not conjured up for our benefit, and records which are consequential in the lives of children in their communities.

In order to give the most conservative answer to these questions we assumed the null hypothesis, pooled the experimental and control group frequencies, and compared the experimental condition with the (pooled) expected frequencies. We also made the standard experimental/control comparisons characteristic by characteristic, for investigators more familiar with that process and its outcome properties.

Processing the data from previous followup investigations and some new data from our search indicated that the experimental and control groups were indeed comparable. Differences in the outcome charts should not be attributed to loss in followup, or dropping out, or social and economic differences. Loss rates were well within acceptable limits (less than 10 percent over 5 years), and a review of the characteristics of remaining pupils does not suggest any special bias. There were no statistically significant differences in dropping out, in the experimental and control comparisons. The neighborhoods the elementary schools served were carefully matched for socioeconomic status. All neighborhoods involved were in one socioeconomic category, the lowest in Warner's five category breakdown. Busing had not yet begun. Stanford-Binet scores produced means for the two groups within .3 of each other. Behavior problem data recorded in the schools, juvenile court, and the police files, if anything, favored the control condition.

Early analysis for comparability of the experimental and control groups suggested three epidemiologic variables which might affect outcome: (1) sex, (2) race, or ethnic identification, and (3) later school environments in junior and senior high. The experiment took place in sixth grade. From there, most students went on to junior high schools, scattering somewhat to the various schools in their part of the school district.

Once we were satisfied that the control group and the experimental group were sufficiently comparable for analysis, we divided the study population into six study groups which were homogeneous for sex, race or ethnic classification, and schools attended after the experimental year.

We found that you could do something about what happens to a child in high school, in terms of social behavior, by teaching certain skills to a sixth grade teacher.

School data indicate a prevention effect, dating from the experimental year, demonstrated in teacher ratings of work habits, taking responsibility, getting along with others, and self-control. By teacher estimate then, the experiment worked. Absences from school suggest that the students estimated a positive effect as well. Absence rates indicate a prevention effect in our largest study group in the experiment (group #2) immediately following the experiment and for the total group by the following year. Differences reach statisti-

cal significance 2 years after the experiment, but the pattern is evident from the sixth grade on. Family file data demonstrate prevention effects beginning in the experimental year and continuing through the four years which follow. The effect tends to disappear the fifth year of the followup, suggesting a need for reinforcement of the intervention about that time. School data confirm the report of a positive ninth grade finding and extend that positive report back to the experimental year and forward into the 10th and 11th grade years by most measures.

Data are subjected to the most conservative test our consultants could recommend and presented also in more typical fashion as a direct experimental/control comparison. They are further tested against epidemiologic variables, chosen in early analysis of the cohort for comparability of the experimental and control groups.

School data also indicate that the prevention effect may be pretty well confined to appropriate later school environments and that it may have been dysfunctional in others. The positive effect for the experimental group is often reversed at Lincoln School.

Community data also indicate a prevention effect which may date from the experimental year, although this effect is not as clear at that point in time as the family file data effect. Statistically significant differences in the proper direction begin 2 years after the experiment, in the ninth grade year, in both police and juvenile court data, and continue into the 10th grade year in the police data. The pattern is clear throughout the juvenile court data: The lines begin to converge after the experiment, cross about a year later, and then remain in proper relationship to each other throughout the followup period. Police data present a very similar set of curves, but the positive effect seems to wear off in the final year of the followup in that data. However, at the very least, juvenile court and police data tend to confirm (1) the prevention effect, particularly the ninth grade finding, (2) extension of the prevention effect into later years, and (3) buttressing the school data findings with findings from social systems of the large community.

The prevention effect appears to be real, lasting, and generalizable to the community.

Recommendations

The major recommendation suggested by our data is that small group techniques from the mental health field should be incorporated in the school classroom. If these behavioral outcomes can result from 1 year of such teaching, it is possible that implementation K-12 would change the face of our problem. The Report of the Joint Commission on the Mental Health of Children and Youth indicated that, of the approximately 95,000,000 persons under 25

years of age in the United States, 2 percent are severely disturbed and need immediate psychiatric care and another 5 to 10 percent are in need of some type of help from mental health workers. If official records are an adequate index, behavior problems are outracing our capacity to deal with them. Prevention is the key to the future.

What works? In a broad sense the teacher training program which constituted the independent variable in the Kansas City School Behavior Project represents a way in which community mental health centers and local schools might more deliberately and explicitly attempt to meet their obligation in the area of the social and emotional development of children and youth. If successful, these programs would both reduce the need for help and increase the effective manpower ratio.

Successes and Failures

The prevention effect and the change in teacher operations which made it possible were major successes.

The major problems associated with the Kansas City School Behavior project seem to have been those generally associated with planning, operating, and evaluating social action programs: meeting the sometimes conflicting needs of the participating interest groups; planning, operating, and evaluating as we went along; and a limited perspective which controlled the data gathered. Most of these problems were a result of the experimental nature of the project and its relationship to the real school world. For instance, it would not be necessary in future implementations to keep the principals out of the classrooms, as was done in the original project. This procedure removed an important source of support that teachers were used to having and needed.

Data suggest reinforcement would be useful for the pupils at about the 10th grade level. Problems associated with the evaluation also need not recur. Tools had to be developed, and methodology built, which can now be utilized by others as needed. Any new experiment in this area should incorporate data on the later school environments, to make recommendations about the nature of the most effective environments for reinforcing the press of the intervention.

Any experimental work should be planned on a basis which can be maintained for at least 5 years, incorporating studies of the later environments, if our experience is meaningful.

Direct implementation need not be accompanied by such an extensive research design. A very few, very simple, outcome factors would suffice to establish accountability.

Funding Sources

The Kansas City School Behavior Project was a pilot experimental project. As such, there was a tremendous amount of staffing and research for planning and evaluative purposes. That part of the project is not necessary to the operational aspects of the intervention. The actual techniques and approaches of the intervention can be used very effectively without any significant expenditure of funds. The project originated with a $25,000 planning grant from local sources. Both the school system and the mental health foundation held NIMH grants to operate and evaluate the project during the decade of the 1960s. The Institute for Community Studies completed that grant sequence in about 1967. The Greater Kansas City Mental Health Foundation reclaimed the project under its contract with NIMH to operate the first Epidemiologic Field Station for Mental Health in 1968. At the Field Station, the project was assigned to Dr. Hartley, who later joined the faculty of the University of Kansas Medical School and completed the project evaluation funded by a grant from the NIMH Center for Epidemiologic Studies.

MUTUAL HELP GROUPS FOR THE WIDOWED

Phyllis R. Silverman, Ph.D., M.S.Hyg.

Widowhood and Bereavement

Grief is a normal human experience that all must know. In our time we have lost the habits of mourning and do not know how to help people cope with the fact of death. We tend to talk of grief as an illness and help people to "recover." However, bereavement can be viewed as a transition state in the normal life cycle. The transition involves a series of stages: impact, recoil, and accommodation.

During the initial impact phase, mourners experience a sense of being lost and of not knowing what to do next. They feel suspended from life; that the deceased is gone holds no reality for them. The recoil period is not always clearly distinguished from the impact phase. It can cover a period of time extending from 1 month to 1 year after death. The mourner experiences his loss most acutely during this period because the numbness has left and some ability to feel gradually returns. Some people report trying to function exactly as the deceased would have liked, as if trying to recapture him in spirit, if not in fact. Angry feelings, empty feelings, and pining dominate. This is a deceptive time since the observer often misinterprets the initial composure of the bereaved as a sign that he will do well. Neither the bereaved, nor the typical helping network in which he participates, is prepared for this letdown, which is quite normal. Often this is seen as a sign of impending psychiatric illness. The recovery period, a time of looking to the future, can occur anytime within 3 months to 2 years after death. The bereaved becomes future-oriented and can consider building a new life without the deceased. Many different kinds of help are required to aid the bereaved to move through this transition.

For the spouse who becomes widowed, the transition involves developing a new definition of self. The role of husband or wife is no longer available to him or her, and he or she has to find a new way of relating to the world. Mutual help is one way of providing some of the help that the bereaved needs during this time. Other

widowed people as helpers provide the newly widowed with a reference group from which to accept what they are going through and to find hope that they can rebuild their world in a different way without the deceased. People can learn from those who have coped well, and while the pain of mourning cannot be prevented, in the long run helping people accommodate and improve the quality of the new life they build as a single person may be the essence of good prevention. Prevention is not simply preventing an emotional problem, but it is improving people's capacity to master the dilemmas of living in a positive way. Mutual help is a way of helping which does not require the individual to define himself as sick and become a patient to be treated or cured.

Developing Mutual Help Groups

The way in which any mental health professional involves himself with mutual help groups can be divided into three activities: making referrals to the groups, becoming a consultant to existing groups, and initiating or helping develop new mutual help groups. The first activity involves the professional the least in the mutual help program, and the last activity involves him a good deal. No matter what the degree of the involvement, there are certain issues that any professional must consider about his relationship and interaction with these groups or organizations. He has to ask if there is some kind of help which he cannot offer because he has not personally grappled with the problem, and does the quality of a service that is offered relate to the extent of the training of the staff? The professional who does not accept that some problems can only be effectively dealt with in the context of a mutual help organization, manned by people who have experienced the problem but who are untrained, will not make a referral or be a consultant to such a group. The mental health professional has to be willing to see that someone else not as well trained as he is can, in some situations, be more helpful. There are certain kinds of information not readily available from someone who has not been through a given experience. The mental health professional has a very different role in the kind of help he offers.

The following procedures can be followed in setting up new programs:

(a) Form a group of helpers — these are interested widowed people who will work in the program.

(b) Decide upon sponsorship for the program — the decision has to be made whether this will be a freestanding organization run by and for the widowed, or a service of the agency run by the professional staff.

(c) Public relations and educating the community — the program has to become known in the community.

(d) Establishing goals — a widowed-to-widowed program involves learning about the newly widowed in the community and having widowed volunteers reach out to them soon after the death of their spouse. Other programs can involve a telephone line staffed by widowed people; an educational series providing information on legal, vocational, social and emotional needs to the widowed; and social groups.

(e) In mutual help the widowed are the primary helpers. They may need help in orienting volunteers and in providing some ongoing consultation for them; at this phase the professional mental health worker can be most helpful. Ongoing groups of helpers serve several purposes: (1) mutual help and education among those widowed who are doing the helping, (2) mutual support and confidence in their work, a sense of community, (3) a perspective on their work, and (4) opportunity to learn about community resources and other kinds of help available.

PREVENTIVELY ORIENTED COGNITIVE EDUCATION OF PRESCHOOLERS

George Spivack, Ph.D., and Myrna B. Shure, Ph.D.

Assessment of Needs and Program Goals

According to completed teacher rating scales, at least half or almost half of the children in any given "inner-city" day-care or kindergarten classroom display behaviors defining ego-control problems, such as impatience, overemotionality and/or aggression, or more than a normal degree of inhibitions, shyness, or fear. Based on the theoretical position of George Spivack, that the quality of social adjustment is largely determined by a group of mediating cognitive properties that define abilities to solve interpersonal problems, the first step in the research to be described was to identify such thinking skills that would relate to common behavioral difficulties in children this age.

Several hundred 4- and 5-year-olds were tested and regardless of IQ (excluding retardates), three thinking skills were found to distinguish youngsters displaying behavior problems from those who were not. These interpersonal cognitive problemsolving (ICPS) skills include: (1) alternative thinking: the ability to conceptualize alternative solutions to typical problems concerning peers and figures of authority; (2) consequential thinking: the ability to recognize "what might happen next" if a particular solution (e.g., "hit him [to obtain a toy]") were actually carried out; and (3) causal thinking: the appreciation of events that might have preceded an interpersonal event (e.g., "He hit me because_____"). A fourth dimension, a cognitive sensitivity to the existence of a problem as interpersonal, also plays an important role in the moral ICPS thinking style of youngsters this age.

Given that some youngsters enter preschool with efficient ICPS skills and others do not, research also focused on how ICPS skills are learned, insofar as the mother plays a significant mediating role in the problemsolving life of her child. Briefly, mother's cognitive ability to solve interpersonal problems relates to her child's ICPS skills, but only among mothers and their daughters. Data suggest

that mother's thinking ability influences her daughter's thinking skills which in turn function as direct mediators of overt behavioral adjustment. Boys are not more deficient in ICPS than are girls. Their thinking skills are also clearly related to behavior. But 2 years of research has indicated that while girls learn a significant portion of their interpersonal problemsolving thinking skills from their mother, boys develop them through other channels.

Given that adjusted youngsters are better problemsolvers, the investigators initiated intervention to improve a child's adjustment, not by direct modification of behavior itself, but by enhancing a child's interpersonal problemsolving thinking style.

After having piloted the program with children directly, teachers were trained to use the program with their class. Mothers from different schools were trained to work with their child at home.

Evaluation

The first goal was to determine the effect of training ICPS skills on behavioral adjustment. Following the first year in which 113 nursery youngsters were trained, the next goal was to evaluate the effects of 2 years of training (nursery and kindergarten). It was also asked, if 1 year is effective, which year is most effective? How long the effects last after training and whether mothers and teachers differ in their effectiveness as ICPS training-agents were also part of program evaluation.

Nature of Intervention

The concepts taught were the same for all groups, upgraded in content for use in kindergarten and modified when necessary for use by the mother with a single child at home. For 10 weeks, the teacher or mother met once a week for training, then presented daily 20-minute games and dialogs that teach prerequisite language and interpersonal thinking skills found related to behavioral adjustment before training. Games include word-concepts as "not," and "same-different," so a child could decide whether an idea is or is *not* a good one, then think of a "different" idea. Listening to people, watching them, and discussing ways to find out about people's feelings and desires were included. The goal was to help the child develop problemsolving thinking skills that would guide him in coping with typical problems (e.g., one child was in another child's way). The child was taught to generate alternative solutions to the problem, conceptualize potential consequences to an act (e.g., "hitting a child"), and to appreciate cause-and-effect surrounding a

given interpersonal event. Thus the child was taught *how* to think, not *what* to think so he could choose and evaluate for himself what and what not to do.

In addition to games and dialogs presented in a sequenced fashion, teachers and mothers were taught how to dialog informally when an actual problem arises. The idea is to extract from the child his thinking about what the problem is and, when appropriate: (1) how he and others feel about what happened, (2) what the child can do to solve the problem, (3) what might happen if a solution is actually carried out, and (4) what other ways he can think of to solve the problem. For example, one child (Gregory) was heard saying to Elizabeth: "Elizabeth, let's play Lotto." When Elizabeth answered "No," Gregory turned to the teacher and moaned, "Teacher, no one will play with me." The teacher then helped him define the problem. "Do you want to play Lotto or do you want Elizabeth to play with you?" Gregory answered the latter. "What can you do or say so Elizabeth will play with you?" He turned to Elizabeth and asked, "Do you like puzzles?" Elizabeth said "Yes," and Gregory zealously got out a puzzle and beamed.

Results

(1) Each year, there was a significant training effect in ICPS skills for youngsters beginning as adjusted and significantly more so for those who initially displayed impulsive or inhibited behaviors.

(2) Trained ICPS improvement directly related to behavior improvement, supporting the position that ICPS functions as a direct mediator of behavioral adjustment.

(3) The ICPS skills most affected were alternative and consequential thinking. Relative to nontrained controls, 1 year of training was sufficient to improve behavior. Results showed that if youngsters were not trained in nursery, kindergarten is not too late. Training effects lasted at least 2 full years following training.

(4) A *preventive* effect of the program was indicated. Significantly more trained than nontrained youngsters who were normally adjusted throughout the nursery year maintained that adjustment throughout kindergarten and first grade.

(5) Mothers and teachers were equally effective as ICPS training-agents. This was true of mothers of boys as well as of girls, despite pretraining relationships of ICPS between mothers and daughters only. ICPS change in the child related to ICPS change in the mother, as well as to her increased use of problemsolving style of interaction when real problems arose at home. Importantly, a child's behavior improved in school as a result of having been trained by the mother at home.

Program Initiation

After clearance for the program from top administrators of Get Set day care and from the director of early childhood education, School District of Philadelphia, the day-care supervisor and school principals were approached for approval. Teachers and mothers participated on a voluntary basis and, after having been informed of the program content, 25 teachers and 40 mothers were trained. During the research years, over 300 children were exposed to the program.

Community Involvement and Incorporation Into CMHC

Funded by contracts from the School District of Philadelphia, the program was incorporated into 26 new classrooms over a 2-year period following the research, with new teachers having been trained by 10 previously trained teachers. Percentages of behavior change were strikingly similar to those of the research years for both inhibited and impulsive youngsters. This is important because it indicates that, with the script and a minimum of supervision, teachers can successfully make the program a part of their school-day. At present, teachers who know the program are training mothers of children in their classes. In addition, Consultation and Education and Part "F" staff of the Hahnemann Community Mental Health Center are being trained to use the program with mothers in the clinics and with children in clinics and schools. The approach is also being used with groups of adult patients at the Hahnemann Community Mental Health Center and is applicable for latency-aged youngsters and adolescents as well.

Concluding Statement

If educators and clinicians have assumed that emotional relief would pave the way for clear thinking in a problem situation, the present program has given support for the reverse idea, that ability to think through and solve problems might pave the way for emotional relief and behavioral adjustment. The program has been found easy to incorporate in schools, in homes, and within the context of a community mental health center. Teachers, mothers, and clinicians respond enthusiastically to the program but, most importantly, so do the children.

B. AGENCY STRATEGIES FOR PRIMARY PREVENTION

AN EPIDEMIOLOGICAL APPROACH TO PROGRAM DEVELOPMENT FOR PRIMARY PREVENTION

Bernard L. Bloom, Ph.D., M.S. Hyg.

This workshop summary outlines the findings from a major epidemiological investigation — the first to study a single community at two different points in time — 1960 and 1970. Major changes had taken place in the organization, availability, and financing of mental health services during this decade, and the study sought to identify the consequences of these changes on the process of identification of psychiatric patients. At the same time, stable findings across this decade of change would help set the empirical stage for the development of preventive intervention services. The methodology of the study was described and illustrated with slides at the workshop, along with the major findings and implications.

Major Findings

A. Tremendous increase was found in first inpatient admission rate between 1960 and 1970

B. Neighborhood characteristics
   1. Social class was not dramatically related to admission rates, although the poor were overrepresented in the mental health service delivery system.
   2. Social disequilibrium as a neighborhood characteristic is very highly related to admission rate

C. Between 1960 and 1970 there was a dramatic increase in the number of Spanish surnamed patients—as of 1970 they were overrepresented in the patient population

D. Economic considerations still play a major role in the locus of psychiatric care
   1. The poor are admitted to public facilities; the affluent to private.
   2. Inpatients are rarely seen in outpatient facilities in advance of hospitalization.
   3. Private facilities play a very small role in the care of readmitted patients.
   4. Males tend to be admitted into public facilities; females to private.
   5. The poor tend to be admitted to inpatient facilities; the affluent to outpatient facilities.

E. Length of episodes of care is short everywhere and getting shorter
   1. Females stay less time than males.
   2. Young stay less time than old.
   3. Mild stay less time than severe.
   4. Private patients stay less time than public—true even for patients with the same diagnosis, sex, and age.
   5. First admissions stay less time than readmissions.

F. Multiple episodes and multiple pathways
   1. Twenty-five percent of patients have a second episode within 2 years.
   2. Repetitive involvement was found in same setting.
   3. If the first *inpatient* episode is in a private facility, the chances are good that the second episode will be in a public facility.
   4. If the first *outpatient* episode is in a public facility, the chances are that the second will be in a private facility.

G. Epidemiological findings
   1. Marital disruption was identified as possible powerful stressor.
   2. Review of literature on marital disruption as a stressor and implications for the development of a preventive intervention program were presented at the workshop.

ORGANIZING PRIMARY PREVENTION PROGRAMS WITH DISADVANTAGED COMMUNITY GROUPS

Vera S. Paster, Ph.D.

The Washington Heights-West Harlem-Inwood Mental Health Council's Community Mental Health Center was a product of social advocacy. Thus, primary prevention activities, especially those which are social advocacy oriented, are of high priority to the community leaders who control the center. The catchment area is in northwest Manhattan, New York City. The catchment area is 50 percent black, 30 percent white, 20 percent Hispanic, ranging from impoverished ghetto residents to middle-class persons in old deteriorating, but still substantial, neighborhoods.

The council's model integrates activities which are definable as primary prevention into all aspects of the program—from the development of the proposal for the CMHC to its governance and service delivery. Socially oriented primary prevention programs, as such, are emphasized equally with services directed to psychopathology. This paper presents several examples.

A survey was taken of a representative sample of the catchment area which elicited, among other things, their major concerns. Priorities clustered around housing, health service and welfare problems, safety in the streets, and problems in dealing with the schools, obtaining legal services, consumer problems, child management, trouble with the police, inefficiency of recreation facilities, and lack of educational and job opportunities. Even though these are consistently issues of concern for urban disadvantaged groups, the survey provided a data base specific to this catchment area for the selection of program content and target population groups.

The goal was to provide primary prevention services to populations at highest risk through enabling them to ameliorate stress in their daily living. Leadership training, provision of crucial information, and development of personal competence through experience in advocacy for community and self-interest were the means. Improvement in the quality of life in the area, a sense of kinship

among neighbors, development of support groups and community linkages, and broad-based participation in the operation of the CMHC were sought-after results. The assumption was that persons who could identify with the community's common interests, who felt informed and competent about dealing with important everyday problems, and who could band with others to influence the social systems that affected them were stronger for the doing and, therefore, more resistant to breakdown.

Example 1

Community members were sought out to plan a series of advocacy training encounters concerning the law, police, and neighborhood consumer problems.

The planners, working with CMHC staff, gained a detailed knowledge of available resources and how to make use of them for the project, learned how to enlist the participation of their neighbors and how to organize a group experience for specific objectives.

They developed a series of two intensive information and encounter experiences around law enforcement, "The Cops, the Courts, and Us," and around consumer matters, "How Not To Be Cheated." In interaction with lawyers, a judge, the precinct captain, a patrolman, and a detective, a large group of people learned about legal procedures, rights, and means of self-protection from the point of view of the victim and the accused. The lines of communication were opened with the police. The lawyers and the CMHC staff together held private consultation sessions for all who needed them on personal legal problems. The CMHC staff, when appropriate, followed up these consultations with advocacy help.

The second experience included representatives of the Consumer Affairs Bureau of the City and of consumer action groups, a home economist, and a vice president of a local supermarket chain. They interacted with the group, sometimes heatedly. A result was the formation of a cooperative buying club, facilitated by the CMHC which provided space for gathering and distributing the produce. Both were 2-day-long Saturday conferences.

These programs attracted large numbers of residents into the CMHC, provided an opportunity for them to meet the staff and to establish the CMHC as a vehicle for the community to use for its concerns. One spinoff effect was the later seeking of help for mental health problems which otherwise would not have been brought to the CMHC. Another was a more elaborate series of interaction-oriented workshop sessions, each televised and shown on public access television.

Example 2

The community board members of the CMHC were interested in dealing with the problem of deteriorated and deteriorating housing and neighborhoods. CMHC staff contacted at least one resident in each of the problem buildings for persons to assume initial leadership. Together they rang doorbells, asked each tenant about housing concerns, and arranged for a meeting in the lobby of the building, during which grievances and concerns could be shared. All subsequent meetings were held in the shared territory of the building hallway. Action plans were formulated which usually included face-to-face meetings with the landlord, as well as with officials of housing and other city departments. The CMHC had established the contacts and power that got the city officials to respond to requests for their attendance. The tenants learned about their rights, about the established procedures for bringing about relief from housing complaints, learned how to deal with public officials and to work as a team. In all cases they were able to experience tangible and sometimes dramatic success in rescuing apartment houses.

In some instances, tenants who had occupied the same apartment house for over 20 years talked directly to each other for the first time. One building superintendent was denounced by all the tenants. Privately he had indicated that he had given up on both the tenants and the building. The tenants became aware of his key role in the building and finally invited him to the meetings. The result was an understanding of each other's point of view, which led to shared responsibility for the building. With the landlord's repairs and paint and tenant-superintendent cooperation, a clean well-kept building emerged from a dirty, graffiti-marred, garbage-strewn tenement.

This work was concentrated in designated blocks. As was the hope, one building group linked with others on certain blocks and became formal and informal block associations. One of these associations raised funds and arranged to turn their block into a recreation street during the summer for use by teenagers whom they had formerly feared.

Example 3

A number of single room occupancy "hotels" existed in the catchment area. One was a particularly notorious eyesore, unanimously considered to be a neighborhood menace. It was inhabited by a combination of the disabled, the aged, exconvicts, drug addicts, prostitutes, newly discharged mental patients, and drifters. It

functioned as a sanctuary from the law, so that purse snatchers, drug dealers, and others similarly engaged sought safety in its quarters and used it for a headquarters. There was a murder a month in the building. The building itself was a health hazard.

CMHC staff, working with some of the outraged residents of the area, brought together the local addiction agency heads, public health nurses, and welfare officials to develop a cooperative attack on the situation. This led to a series of meetings with the fire department, the police, housing officials, and the mayor's office.

Results were that the landlord was forced to evict the active criminals, repair the building, provide space for meetings, and provide security doors and guard service. All tenants referred by the welfare department were screened in order to balance tenancy. Hot lunches, regular medical checkups, group and individual advocacy, psychotherapy, and drug counseling services were all provided at the hotel, with residents and agency personnel working together to do so. Again, many of the residents were helped to avail themselves of needed services at the CMHC building, several became active in the CMHC's Council, and two served as trainer-consultants for community education programs.

Our Learnings From These Programs

The earlier community members participate in the planning of the programs, the better.

The more responsibility community persons assume for the programs, the better.

The more CMHC staff see themselves as resource persons, and as encouragers, and the less they need to claim "credit" for the results, the better.

The less CMHC staff rely on their professional titles and positions for authority, the better.

The more power and know-how the CMHC develops, so that they can help bring about the cooperation of the appropriate government officials and agencies, the better.

The more the target participants "own" the programs and take them over, the better.

The more realistic the goals, so that success is achieved, the better. Problems must be significant, but success is nevertheless essential, especially in the beginning.

The more focus on the strengths of the persons worked with, the better.

We found that the best primary prevention programs are those that develop ongoing and self-renewing support groups, and that programs that equip people and provide them with experience in

confronting the system for their own betterment, and making the system work for them, produce the sense of hope and competency that is particularly effective primary prevention for oppressed minority populations.

Problems

- Making and sustaining contact with the isolated and maintaining their involvement
- Managing the demands for medical model activities imposed on the CMHC by regulatory agencies, while maintaining a primary prevention focus
- A tendency for the more aggressive to take over and the less assertive to drop out
- Goals becoming diverted
- The CMHC program unwittingly becoming polarized through the activity of persons who are antagonistic to other target groups in the community

Evaluation

Because of budget staffing limitations the CMHC had no research capability. Observational evaluation of these approaches in relation to primary prevention of mental illness made us notice, however, that:

- active participants seemed more hopeful and more energized toward coping with their own problems;
- persons who otherwise would never have sought help from the CMHC did so, and in so doing tended to bring to it less severe problems;
- a number of women, supported by public welfare, became active in center programs, want back to school, or found employment. So far, CMHC activities launched six awarded BA degrees; and
- isolation, apathy, low self-esteem, powerlessness were all lessened among those who were actively involved. Those who were already the doers were reinforced. Natural leaders were discovered.

These are the elements of primary prevention.

AN APPROACH FOR CULTIVATING PERSONAL AND LEADERSHIP SKILLS IN THE COMMUNITY

Merrill F. Raber, M.S.W.

The Prairie View Mental Health Center historically has experimented with a variety of primary prevention approaches. In 1968, increasing uneasiness about the effectiveness of "speech-making" and doing things "to" and "for" the community helped open the door to considering ways in which "experiential" learning might be useful in working with the community. Several staff persons had been involved with National Training Laboratories (NTL) programs and were interested in the applicability of laboratory training in effecting the climate of a given community.

The timing of this beginning exploration was particularly significant in light of growing concern about the Harvey County community. Two school bond issues had been rejected; efforts at getting the community moving on any front had been frustrated; those who emerged as leaders tended to get "shot down"; and, in general, a climate existed of stagnation and frustration. It was to this kind of setting that the idea of experimenting with a different kind of approach to leadership training was considered to be worth a try, in spite of the risks and the uncertainties about how such an effort might be received.

There were approximately a dozen persons in the Harvey County community who had had some experience with, or awareness of, the laboratory approach to learning. These persons were professionally involved in industry, clergy, college education, mental health services, etc. A beginning step was to bring these persons together to talk about how the common base of experience-based learning could be applicable at a total community level. Although it seemed like an interesting idea, there were a lot of uncertainties and hesitations as to whether or not this kind of approach would be possible and acceptable in an actual community. It should also be clarified that Harvey County's population is 27,000 and the largest city, Newton, has a population of 17,000.

After about 6 months of talk, it was finally agreed to try the first "community leadership training laboratory." This was a weekend event at a camp site some 90 miles away from the Harvey County community. Recruiting for such an adventure was monumental, and yet the group that had been meeting and planning had enough influence in the community to muster 24 leadership persons. The staff for this first event were primarily from outside. In spite of the misgivings, this first event turned out to be a good experience for the participants. Real steps were made in understanding the processes occurring in the community, understanding leadership issues, and learning to know and trust each other.

As a result of this first effort, an organization was formed known as "Leadership, Inc." (LINC), which became the basis for a 5-year effort in dealing with community change and community conflict. Funds were secured through Title I (Higher Education). Prairie View Mental Health Center provided administrative time; NTL provided moral and financial support and were quite invested in the task; but the community board of LINC was ultimately responsible for decisionmaking and the entire process. Below are listed the goals that were developed by the board for the LINC organization:

(1) Identify, diagnose, and understanding key community problems which inhibit individuals and groups from functioning in an effective way for the betterment of the entire community.
(2) Develop methods and programs to alleviate community problems identified by the community and to improve undesirable behavioral patterns in a community.
(3) Coordinate with other community planning groups in order to facilitate, rather than duplicate, total community planning and focus particularly on human factors in community planning.
(4) Reduce barriers to effective communication between various community groups; reduce community resistance to change; decrease cynicism, apathy, and distrust.
(5) Develop community leaders and facilitate their functioning in whatever capacity they are presently serving.
(6) Mobilize resources, develop programs and individual leadership skills which will help bring about a community climate characterized by:
    (a) Freedom from social and interpersonal conflict that becomes destructive to community life
    (b) Ability to deal with conflict in a constructive way
    (c) Various sectors of the community sensitive to and mutually supportive of each other
    (d) Understanding, welcoming, and bringing about change in a positive, innovative, and orderly manner, and
    (e) A "caring" community which makes it possible for various sectors to be effectively interrelated and interdependent as the need arises.

The subsequent story of the role LINC played over the next 5 years in the community is dramatic and significant. It is sometimes

difficult to know exactly what the impact of such an effort has been in the community. At the same time, various informal research efforts suggest that the LINC experience contributed greatly to a significant turning point in Harvey County. Today, the community is "on the move." A new school, a new library, a new community center, a new city building, improved communication between various racial and ethnic groups, all have received an impetus through LINC.

Perhaps one of the most appropriate organizational "deaths" is also dramatized through the LINC experience. With some concern that an organization originally established to meet a need not be perpetuated indefinitely beyond its usefulness, the LINC board carefully examined its role in the community and the time and energy required to maintain the organization beyond its initial 5-year role. After careful consideration, the board decided to disband at a time when energy and enthusiasm were still high and when people were able to dissolve the organization with regret but with a feeling of appropriate termination, rather than termination by exhaustion and frustration. This process was carefully worked through over a period of 6 months.

A followup to the LINC momentum has occurred in the 2 years following. With some money left over from the LINC board, a conference entitled "Harvey County 1985" was developed in October 1974 to bring together 125 leading citizens from the entire county to consider what the future should look like for Harvey County. Because of the enthusiasm of this conference, funds were received from the Kansas Committee for the Humanities which then developed year-long multiple task force studies on eight areas for the future that culminated in a second major conference in November 1975.

The workshop will discuss the LINC story in some detail and allow for small group interaction around the applicability of this experience for other communities.

DEVELOPING PRIMARY PREVENTION PROGRAMS WITH MAJOR COMMUNITY INSTITUTIONS

Robert R. Santos, M.S.W.

Introduction

This workshop will describe the entry and programing process followed by one Primary Prevention Program for Children in developing services in major community systems. The Primary Prevention Program described is a separate, designated unit within the Community Mental Health Center in Wilkes-Barre, Pa., and was funded in October 1974 for an 8-year period by NIMH. The Program's emphasis is to work with the adults in the child caregiving community systems who significantly influenced the child's development. Programing is concentrated toward transitional/crisis times that children experience. The staff includes a program director with six multidisciplinary professionals divided into three, two-person teams, one team for each program area: Infancy and Early Childhood, Childhood, and Adolescent/Young Adulthood.

Since the public school system is the major caregiver of children after parents, the Primary Prevention Program directed its initial program effort to that community system. The entry and programing process that will be described lends itself to a broad range of program efforts and has been successfully adapted for use in other community systems. A community system is defined as a collection of several organizations which provide similar services; for example, a community system is the public school system, and within that system there would be several school districts.

Staff Selection

The first task was determining the criteria of staff selection. Since, initially, four of the six staff members would be working in the schools, two having that as their primary responsibility, the

essential qualifications were teaching experience, a supportive and positive attitude toward schools, ability to establish collaborative relationships, and group work experience with children and parents. Other significant factors included knowledge of the system, realities of programing within the system, and a realistic sense of the needs of system personnel.

Precontact Activities

The first precontact activity was examining the community's view of mental health services and, in particular, this community system's view of and experience with mental health services. In the case of this Primary Prevention Program, mental health services were viewed by the general community as being treatment focused, and the public school's view strongly reflected this expectation. Their attitude toward mental health services was not positive, and primary prevention programing thus would require a shift in their attitude and view of mental health services.

Next, it was decided to contact all six of the school districts in the catchment area and to meet with them individually to assess receptivity of each to program implementation. The Program's decision was to plan with the district or districts that indicated the most interest and to leave those which were less receptive or negative to a future time.

In the case of the public school system, the Primary Prevention Program made initial contact with the superintendent in each school district. This route was chosen because a superintendent has the power to (a) sanction or dismiss any new program, (b) commit resources such as staff time or funds, and (c) give the Program access to any level of staff within the system. In terms of future planning, he would be able to approve of Program expansion from one staff level or school to another. Also, he is accountable to a political body for the Program's success or failure in the schools and thus should be fully aware of and knowledgeable as to what the Program would and could do in the school district.

The next step in the precontact activities is to determine initial target objectives for entry. For the public school system, target objectives are shaped by consideration of such factors as: number of school districts, number of schools within a district, school levels (elementary, middle, etc.) and categories of school personnel. The original target objectives were set at obtaining access to an elementary school and a high school in one of the districts in order to conduct a needs assessment.

The final precontact activity was to determine the contact procedures that would be followed in making entry into the commun-

ity system. For the school districts, the procedures consisted of the development of a brief statement of primary prevention and its general application to the community system, a telephone call to the superintendent as the top executive of the organization to arrange a meeting, sending him the statement in advance of the meeting, deciding who would conduct the meeting from the Program, and conducting the meeting itself. The brief statement contained a conceptual description of primary prevention, service categories, staff background and stressed the desire for a collaborative relationship.

Contact Procedures

In conducting the initial entry meeting(s) with the superintendent, an assessment of his interest in the Program is made. The Program is explained, issues raised in terms of applicability to the organization, questions answered, and target objectives indicated. If the superintendent indicated initial interest, he was asked to channel the Program to appropriate top-level administrative personnel with whom negotiations, selection of service and school, planning, implementation, evaluation, and renegotiations of service could take place. Over the course of the meetings with the superintendents, shifts in the original target objectives occurred, from involvement on a secondary school level where the school districts wanted a clinical role as opposed to a primary prevention service. Therefore, the Program decided to concentrate initial efforts at the elementary level where there was more possibility of maintaining a primary prevention focus. A second shift was from a needs assessment approach to program development to offering a range of possible services from which the superintendent and his top administrators could select those needed. Needs assessment as an initial way to enter the school was too vague and too threatening for the schools to understand and accept. However, it was accomplished in a concrete way through the development of a program service plan in which were outlined the primary prevention services which could be provided to teachers, school administrators, counselors, parents, and the system itself. The top administrative personnel then selected the service and the target population which they felt should be addressed.

Channeling and Negotiations

The above shifts occurred simultaneously with the channeling process to top-level administrative personnel which was done to

engage them in the activities of the Program. In the first two school districts, the superintendent channeled the Program to the director of special services. In the remaining school districts, the superintendent was asked to channel the Program to the assistant superintendent for elementary education since that was the level on which the Program would be involved. If the Program was initially channeled to the director of special services for negotiations and planning, that director would attempt to refocus and redirect the Program into a clinical service. If the Program was channeled to the assistant superintendent for elementary education, he was more readily able to understand and accept the Program's purpose and focus.

Planning

The top administrators selected the program service and the target school and then included the principal and/or teachers from the selected school in the planning meetings. Each district selected their largest elementary school. The program service selected in one district was a parent education program; the other two districts selected a teacher education program.

Implementation

The parent education program and one of the teacher education programs will be described to illustrate the programing process. The models for integrating the service into the school system and the shifting of roles of the target population, i.e., parents and teachers, from service recipients to providers, will be highlighted.

Work with Parents on School Entry

Consistent with the philosophy of this Primary Prevention Program, programing effort is focused on the natural crises in the developmental cycle of parent-child relationships. The school's selection of the child's entry into school was a most appropriate issue. The focus of the parent education program became the separation of the child from home to school. The program was offered to parents of kindergarten children from the largest elementary school in a semirural school district. It was implemented 1 week prior to the school's beginning and was a six-session program based on a small group model utilizing a discussion format and mutual support; 26 parents attended. Co-leading each of the two small groups of

parents was a staff member from the Primary Prevention Program, the school's kindergarten teachers, and a social worker from each of the community's family agencies. Use of a worker from the family agencies in this program resulted from the Primary Prevention Program's intention to involve other community agencies in order to stimulate their programing beyond the clinical model in a system in which they were already involved, i.e., the schools. The kindergarten teacher was essential because she provided immediate observations concerning the children's separation reactions in the classroom situation. The parent education program provided an excellent vehicle for parents and teachers to develop an initial communications network which would serve to avoid future difficulties, as well as ease the child's (and parent's) separation and adjustment process.

At the completion of the parent education program, parents who participated were asked to form a needs assessment group to make recommendations on parent education programs in the district. The group of 10 parents met three times and later met with the superintendent, assistant superintendent, and building principal to convey their recommendations. All their recommendations currently are being implemented in the district. As part of the group's recommendations, the school entry program for kindergarten parents will be implemented in all the elementary schools of the district. Parents from the needs assessment group will participate in the planning group for this year's school entry program. This planning group is composed of all the kindergarten teachers, nine parents, the two elementary school principals, and two family agency social workers who were involved as co-leaders in last year's parent program on school entry. In addition, parents will function as co-group leaders in this September's school entry parent program in the elementary school in which the program was implemented this past year. The parents will be involved in all aspects of planning and presentation along with a kindergarten teacher and family agency social worker. In summary, the role shifts for the parents occurred in changing from recipients of the parent program to needs assessors, later to planners of the parent program, then to recruiters of other parents, eventually to cogroup leaders, and thus to providers of the service.

Evaluation

Evaluation of the school entry parent program occurred along several dimensions: (1) the administration of a pre- and posttest questionnaire to the participating parents; (2) a subjective, verbal evaluation of parents and group leaders in the sixth meeting; (3) the needs assessment group; and (4) reactions from administrative personnel with whom the program was planned.

Teacher Education Program

The teacher education program, which was implemented in an urban school district, followed a somewhat different process. After receiving administrative sanction for a teacher program and selecting the school, negotiations ensued with the principal from the district's largest elementary school. The process agreed upon was to first describe the Primary Prevention Program to all of the teachers in the school, grades K-6 and then ask for volunteers from the teachers in grades K-3 to whom the program would be directed. Those teachers who volunteered initially formed a needs assessment group. Using inventory techniques, they met twice and selected the focus of school entry, the impact of family changes, and the child's adjustment in the classroom situation. The program consisted of six weekly half-hour meetings at the beginning of the schoolday, utilizing a small group format emphasizing discussion and mutual support.

Teachers were asked to form a planning group to develop recommendations which they would convey to the top administrators. This planning group, sanctioned by the top administrators, met twice in the half-hour morning timeslots and selected five major areas from which particular concerns and specific recommendations were to be shared with administration. After two planning meetings, the building principal met with the teacher group to react to the recommendations and to offer suggestions for sharing them with the top-level administrators. Recommendations include teachers assuming co-leadership roles in parent discussion groups and the continuation of the teacher group discussion program. As co-leaders in possible parent discussion groups, the teachers' roles will shift in a manner similar to that described above for parents participating in the school entry program.

Since the integration of the primary prevention service into the community system is a key goal, several steps have been followed to achieve that end. The first step was to include key administrative and line staff, i.e., kindergarten teachers, with Primary Prevention and family agencies' staffs to deliver and evaluate the particular service, for example, the parent program. For the first planning and delivery of the parent program in a school, the Primary Prevention Program funds the cost for the teacher's time to participate in the planning and delivery of the program. The next time the program is planned and delivered, however, the system is requested to assume the cost for the teacher's time. At the time of the second planning and delivery of the parent program, staff from the Primary Prevention Program shift to a consultative, supportive role to the group leaders. The next step in the integration of the service into the system is to involve in the planning group not only teachers and principals, but also parents and an elementary guidance counselor.

In conjunction with the previous step, the final steps in the integration process are to expand the program to other elementary schools and to allow sufficient implementation time so that enough staff and parents have opportunity to participate. This broadens the grassroots base of the program and insures its support and continuation. The integration process for the primary prevention service is linked to, and occurs simultaneously with, the shifting of roles of recipients to providers of the service. These two joint processes insure the continuation of the primary prevention service without the direct staff or final support from the Primary Prevention Program and turn it into a community program as opposed to a mental health center program.

The entry and programing process described in this paper has been used in community systems other than the public schools with success; using the process in less complex community systems requires minor adjustments.

C. ASPECTS OF PREVENTION

FUNDING—WHO PAYS WHEN NOBODY'S SICK?

Frances Z. Baxter

With cutbacks in mental health and human service funding, the development and expansion of prevention programs is dependent upon making effective use of a variety of funding mechanisms.

As primary prevention program plans are developed, many different groups in the community will be working together, e.g., civic clubs, scout groups, men's and women's clubs, Jaycees, church groups, parent groups, and the mental health association. Linkages can help provide financial as well as manpower assistance.

An important aspect in funding prevention programs is the ability to reach for many different funding sources and to be flexible and creative in the search for funds. For example, a major foundation will fund a new program or a portion of a new program, but it is important to have built in a plan for picking up the other pieces.

The workshop will review funding sources on the following list, concentrating on those of most interest to the participants:

Federal Programs

I. Mental Health Programs
   - CMHC Planning Grants
   - Consultation and Education
   - Rape Prevention and Control Program
   - Applied Research Grants
   - Children and Family
   - Aging
   - Crime and Delinquency
   - Minorities

II. Drug and Alcohol Programs
- Formula Grants to States for Drug Abuse Prevention and Treatment
- Drug Abuse Education
- Formula Grants to States for Alcoholism

III. Developmental Disabilities

IV. Crime and Delinquency
- LEAA Programs
- Other Special Youth Programs
- Special Emphasis Prevention and Treatment Program
- State Grant Programs

V. Health Revenue Sharing Grants

VI. Low-income Housing for the Elderly or Handicapped
- Community Development Housing:
  (Program Includes Social Services)
- Program #202—Housing—Low Interest Loans:
  (Facilities for Social Services)

VII. Child Abuse Prevention and Treatment Act

VIII. Elementary and Secondary Education Act
- "Counseling"
- Titles I, IX, X

IX. Social Security Act, Title XX

New Legislation

- Higher Education Act
- Health Education Fund

Resources

- Legislation—available from Representative in Congress
- Catalog of Federal Domestic Assistance
- Federal Funding File published by Morris Associates

Government Contracts

- Resource—Commerce and Business Daily

State and Local Monies

- State and Local Taxes
- Revenue Sharing Monies
- Federal Block Grants—State plans
  - Health
  - Education
  - LEAA
  - Others

Private Sources

- Major Foundations
  - Identifying appropriate sources of funding
  - Tips on grantsmanship
- Small Foundations and Corporate Giving
- Community Support
  - Identifying the resources in your community
  - Organization sponsorship
  - Volunteer programs and help
  - Special events

INVOLVEMENT OF THE COMMUNITY IN PRIMARY PREVENTION

Merrill F. Raber, M.S.W.

As illusive as primary prevention may be, the main consideration can be stated as "How to keep people out of mental health treatment centers." In other terms, it's how to reduce the incidences of dysfunctional emotional stress which create the need for clinical services. Thus, developing strategies for having an impact on the environment to help reduce the risk of disorders in the entire community becomes the task. The whole concept of primary prevention has always been an interesting theory, but to get the staff and community involved in the process has been a major undertaking.

A basic principle underlying community mental health in its totality is that mental health and mental illness or, more appropriately, emotional well-being and emotional stress are the responsibility of the total community and not the special property of any vested interest or group, namely mental health professionals. While the professionals have special areas of competence and technical skill, the problem of mental health and the prevention of mental illness are ultimately a community task. Frequently, mental health programs have developed from what the professionals traditionally like to do and, to a lesser degree, have been shaped by the mental health needs of a community. How then do you involve the community in taking responsibility for concepts of prevention?

At Prairie View Mental Health Center, Newton, Kans., the effort to get the community involved in dealing with concepts of prevention and, at the same time, to have staff feel the support of the community in doing this kind of work has been a long and sometimes frustrating road. Over a period of 15 years, since this has been a major thrust of the Prairie View program, we have been able to document some things that have been learned through both success and failure. The workshop will attempt to pinpoint some of the kinds of approaches that have been used in making the task a joint effort of community and staff.

Below are listed some of the kinds of efforts, utilized over a period of time, that will be discussed in the workshop:

(1) Mental Health Board Education: Moving from supporting clinical services only to putting major priority on education, consultation, and prevention.

(2) Community-Staff Study Groups: Involving community care-givers as peers in discussing human/mental health issues together.

(3) Luncheon Groups: Regular meetings at the center for raising community awareness and sensitivity to mental health issues.

(4) Community Resource Councils: Collaborative effort to meet with other agencies as "peers" to coordinate preventive services.

(5) Teacher Training Programs: Include graduate credit for seminars on "teacher effectiveness" and "therapeutic intervention in the community for children with problems."

(6) Family Life Education: Public seminars on depression, stress, anger, etc., with community persons co-sponsoring and leading small group discussions, Family Life Education Councils in each county, Family Life plays, Mothers' Day Out, parenting seminars, etc.

(7) Community Visiting Nurse: Full-time effort to be available to intercept and work with families before referrals need to be made.

(8) Seminar on Counseling: Ongoing case-centered training for community care-givers, with monthly followup with therapist/consultant.

(9) Child Services Coordinators: In each of the three counties, coordinators for total services to children to make sure children and their needs do not "fall between the cracks."

(10) Jointly Sponsored Seminars: Relating to public policy and children. Funded by National Committee for the Humanities.

(11) Employee Assistance Program: Training industrial supervisors in dealing with employees' personal problems.

(12) Resource Fair: Emphasis on collaborating with community and presenting total resources available for wide range of human problems.

(13) Socialization Groups: Effort to involve nursing home residents in growth-oriented activities with emphasis on training nursing home staffs.

(14) Caring Place: Centered in downtown area for anyone needing and/or desiring support, skill training, and socialization.

(15) Worry Clinic: Opportunity for citizens to talk about things on their minds and to get response from resource persons.

(16) Church and Human Relations: Community committee independently funded to work with staff in making local church congregations more effective in areas of prevention.

(17) Leadership, Inc. (LINC): Community committee independently funded to work with community and staff in leadership training.

(18) Growth Services (Growth Associates): A division of Prairie View totally designed for growth-oriented seminars, workshops, training events, and organization consultation. Examples: Human Experience Series, Weight Control Training, Gestalt Encounter, New Frontiers of Healing, Life Development Lab, Couples' Workshop, Human Interaction Labs, Psychosynthesis, Fair Fight Training, etc.

Rather than develop a department for prevention or education/consultation, the Prairie View organizational structure has attempted to incorporate the prevention concepts into the assignment of a wide variety of staff persons. The primary mandate for prevention is with the Division of Community Services. The range of activities is now so vast that there is increasing concern about how to keep all of the activities coordinated and organized to maintain organizational continuity. Recordkeeping, quality control, and accountability are being faced as preventative type services proliferate. Where 10 years ago only a few people were involved in preventative type activities, today most of the clinical staff (Community Services) have a wide range of involvement with the prevention activities. The Prairie View "event monitoring system" is the computerized control point for recording and documenting all services, including prevention-type services. Each person accounts for the activities of the entire day which are coded and computerized. The printout each month then gives a total for all the kinds of service, including the financial accounting.

To keep in mind that concepts of prevention can only be as successful as the community wants them to be has been uppermost in the thinking at Prairie View. Getting community intellectual support is only half the battle; getting community involvement and participation in the planning and doing has been more difficult.

THE MANAGEMENT OF PRIMARY PREVENTION PROGRAMS

William G. Hollister, M.D.

The Task and the Suggested Approach

Use a systems analysis approach (i.e., analyze the inputs, process, outputs, constraints, feedback) to outline and define the work involved in setting up, operating, monitoring and maintaining, evaluating and improving the following dimensions of a primary prevention program within a local comprehensive community mental health center. The continuing management of the program will be profoundly affected by the processes used to develop the program.

Basic Considerations

Key dimensions of the development and management task should be examined and worked through by a developmental task force appointed to create a primary prevention program. Although the tasks listed below follow a general chronological order, some will have to proceed simultaneously:

A. Assessment and Verification of Needs (done by task force and consultants)
   1. Set up a center-wide advisory group to guide the program development process — select persons for interest, competency, and representation of all center units.
   2. History taking — what has been done before in the center and the community by whom, to whom, and how.
   3. Key information interviewing — to gather subjective data of needs from center and allied agency staffs as well as consumers, general citizens, and government.
   4. Use of community need assessment technologies — social surveys, social area analyses, etc.
   5. Retrospective analyses of clinical records to detect cases where preventive services could have been offered.
   6. Analysis of this input data to designate the key target groups needing services; i.e., vulnerables groups, demographic areas on which to focus.

7. Developing the plan, mechanisms, and contacts to permanently carry on a continuing assessment of current needs.

B. Development of Sanction to Plan and Develop (done by task force with consultation)
   1. Utilize the verified need data ("A" above) to win administrative approval to proceed with detailed planning of a possible program.
   2. Screen literature and use consultation inputs to explore new ways in which the various verified needs might be met.
   3. Create and assemble materials on possible program choices and outline how these programs relate to the center's missions and goals, how the programs would interrelate with other center and outside agency programs now in operation.
   4. Involve, through the advisory group, a maximum of the center's staff in examining the needs data and selecting which program choices are most feasible locally as well as to indicate possible priorities for immediate or long-range development.
   5. Generate a set of possible first-priority programs for center staff and administrative approval in principle only, with sanction to now explore their implementation requirements and problems.

C. Implementation Planning (task force job)
   1. Assessment of existing resources — current programs, persons, and other resources with which to link.
   2. Exploration and development of possible collaborations — check out linkages with existing community agency prevention programs and activities. Assess possible territoriality overlaps and conjoint project possibilities. Set up a community advisory group representing allied agencies, consumers, and government to (a) provide data on needed resources, (b) review emerging plans, and (c) propose interagency collaborations.
   3. New resources needed listing — identify immediate and long-range additional resources that are feasible to develop; originate a resource development plan which can be continuously extended as planning proceeds.
   4. Plan individual prevention projects in terms of goal setting and resources needed. For each project, identify specifically the need addressed, target group to be served, project purpose and goals, methods to be used, content to be delivered, staffing competencies, and time required.
   5. Evaluation planning — delineate from purpose and goal statements the specific outcomes desired, the indicators for each outcome, and the measurements of the indicators to be used.

6. Preliminary costing estimation set forth the anticipated:
   a. setting up or development costs
   b. feasibility trial costs
   c. full-scale operation costs
7. Using the in-center and the community advisory groups, continue to involve and educate the rest of the center staff and key personnel of allied agencies by:
   a. representational involvement in decisions
   b. periodic inputs of progress to date
   c. periodic requests for them to review and enrich plans under development
8. Submit implementation plan to administration to win approval for feasibility trials.

D. Design and Implement Feasibility Trials of Each Prevention Project
   1. Select representative target group for field trial.
   2. Set up evaluation and monitoring mechanisms for field trial, including feedback from staff, allied agencies, and consumers.
   3. Define the intervention and train the team in the interventions.
   4. Do field trial and collect data on inputs, process and outputs, constraints, and operating costs.
   5. Redesign and recost each project based on feasibility test learnings.
   6. Select the projects to become the beginning prevention program.

E. Establishment of the Staff Organization Necessary to the Program
   1. Based on steps A, B, C and D above, design and define the leadership responsibilities and the necessary staff roles for the prevention program.
   2. Establish the staff organizational structure that is needed by:
      a. Analysis of the kinds and levels of competencies and skills needed to operate the selected projects
      b. Analysis of the competencies and skills of available staff that can be used
      c. Delineation of the competencies and skills needed in persons to be recruited
   3. Designate program leader (pro tem) and provide him or her:
      a. Time to shape and buy into the final program plan
      b. Time to structure the organization in accord with 2 a, b, c
      c. Opportunity to interview and select the staff he/she will nominate to administration for final approval. This would include preliminary, not final, discussion of the "interpersonal contracts" between the leader and prospective staff members re their roles.

4. Design a plan for future recruitment and orientation of staff as well as plans for the continuing education of all staff.

F. Final Presentation of the Total Program to Obtain Mandate. Since the process to date has proceeded under temporary sanctions such as approval to plan a possible program, approval in principle, and approval for feasibility trial, steps now are needed to consolidate a basic mandate to operate the program.
   1. Care should be taken so that all allied agencies and all center staff involved or affected by the prevention program be given involvement in defining the programs to be finally submitted.
   2. The final program design, after having been field-tested and shaped by all those who will be involved, is presented for administrative approval with an attached program budget fully justified. Freedom to consider administrative, financial, legal, governmental, public relations, and program balance considerations should be included in the final approval process.

G. Select and Hire New Staff
   1. After final administrative approval of the proposed prevention program and its staffing the program leader can then:
      a. recruit
      b. individually negotiate the roles with each new employee
      c. set the supervisor-supervisee contracts
      d. mutually define the criteria that will be used in employee appraisal
      e. set the dates for periodic appraisals
      f. set up opportunities to renegotiate the role as experience develops
      g. define the benefits and privileges of the job, to establish and communicate the personnel management pattern — pay, privileges, rights, expectations, responsibilities, and procedures re leave, educational development, grievances, etc.

H. Setting up the Management and Operations Processes. Once basic program relationships sanctions and mandate have been achieved (A-G), the project staff can move on into establishing its operational policies and procedures.
   1. Governance development
      a. Finalize staff structure, lines of communication and authority
      b. Make clear the delegations and accountability obligations
      c. Identify the decisionmaking and program planning mechanisms to be used — i.e., the who, what, where, and how decisionmaking and planning are to be done

d. Establish the policymaking process and who can make policy, delineating the mechanisms of nominating needs for policy, of appeal and of communicating policy
e. Set up staff ideas suggestions and grievance mechanisms
f. Organize staff communication patterns — i.e., schedule of meetings, supervisory contacts, memo distributions
g. Organize record and filing system and appoint those to monitor and periodically review the system's adequacy and utilization
h. Designate liaison persons to other center units and to community groups; delineate their tasks, representation authority, their limits and how they must process liaison decisionmaking
i. Seek legal counsel and brief staff on legal responsibilities they have with regard to clients, agencies, other staff and themselves

2. Setting up and maintaining the financial management
   a. Review and brief staff on the budget and budgeting constraints (what you can and cannot do with the monies)
   b. Negotiate the budget allocations of program monies to projects and support functions
   c. Brief staff on expenditure and reimbursement forms and procedures
   d. Establish and maintain the mechanisms for periodic expenditure monitoring and reallocation of funds
   e. Organize on a year-long basis the preparation of program budgets and the gathering of performance and cost data to justify the next budget appeal
3. Develop with staff the program performance analysis, program evaluation, research, and program development procedures. Set up the program controls and records mechanisms.
   a. Set up the program data record mechanisms to provide information for future budget justifications, evaluations, program development, and staff promotion justifications
   b. Devise system to record client contacts, hours, and kinds of service provided and outcomes; link in with mental health center's central evaluations and performance monitoring system
   c. Set up the continuing program and record-monitoring mechanisms to implement quality of care records reviews, medical audits standards compliance reviews, peer reviews, utilization reviews. Plan how the findings of these are to be translated into better program development and operations, inservice training needs of staff, and on into planning new programs and budgets

d. Identify, analyze, and list according to priority the basic and operations research opportunities and interests in the program and the staff. Develop programed research and evaluation activities with a budget, time, and essential supports

e. Designate the persons and procedures for organized periodic program development efforts to plan new programs and budgets

4. Organize the staff development program

a. Set up expectations of on-the-job improvement and education in annual supervisor-supervisee work contracts

b. Develop periodic mechanisms for employee self-assessment and staff's group assessment of their learning needs

c. Set up a mechanism for staff decisionmaking and equitable allocation of opportunities for self-development via in-service training, educational leave, use of consultants, apprenticeships, program visits, supervision, conference and workshop attendance, etc.

Chapter V

OUTLINE PLANS OF CONFERENCE WORK GROUPS

OUTLINE PLANS OF CONFERENCE WORK GROUPS

Strategies for preventive intervention must be directed to well-delineated target populations composed of persons considered at risk. To emphasize this approach by means of a learning exercise, conference participants were divided into five and six person work groups. The assigned task was to outline plans for a primary prevention program on behalf of a designated target population. Work group assignments were based on participants' choices from among the following target populations: parents-to-be, preschool children, elementary school children, secondary school students, single parents, unemployed persons, pre-delinquents, families with hospitalized members, poor people, bereaved persons, and newborn infants and their mothers.

A considerable portion of the time period on the afternoon and evening of the second day was allocated to the work groups to formulate objectives and outline suitable strategies. Staff consultation was available to each group, and participants were given guidelines for the task and broad outlines to be covered in their deliberations (appendix J). Prior to initial convening of the work groups, Dr. William G. Hollister addressed the conference on the topic, "Basic Strategies in Designing Primary Prevention Programs." This presentation was followed by an opportunity for work groups to practice applying relevant concepts. Additional input for the work groups was provided halfway through the work period by a set of concurrent workshops on Aspects of Prevention which covered the following topics: funding, community involvement, evaluation, and management of primary prevention programs.

Plans designed by the work groups were duplicated and distributed so that copies of each group's deliberations were available to everyone on the morning of the third day, thereby becoming part of conference take-home materials. Three representative plans were presented at a general session and commented on by the Project Response Panel which included Dr. Thomas Plaut, Deputy Director of NIMH; Richard C. Hunter, Program Director, NAMH; and Dr. John Wolfe, Executive Director, NCCMHC. Panelists

selected aspects of each proposal deemed especially innovative or representing approaches that might be widely applicable at the community level.

Selected outline plans are presented in this section to provide an indication of the variety of proposals and scope of thinking forthcoming from the work groups.

OUTLINE PLAN — WORK GROUP E

POPULATION AT RISK: SECONDARY SCHOOL STUDENTS

1. TARGET POPULATION: Sixth graders of any school. Since the seventh grade involves a year of transition from elementary to junior high school, this population must deal with a number of changes including: shift in school buildings, increased academic expectations, larger class size, different teachers, different subjects, etc.
2. MAJOR STRESSES:
   a. Adolescence: physical changes (body image), emotional changes (including emergence of sexual feelings)
   b. Expectations: self (internal), teacher, parents, peers
   c. Striving toward sense of identity: purpose, unique talents, "Where do I fit in?"
   d. Economic: money needed for dating, clothes, drinking, etc.; symbolic value of money ("How much am I worth?"); economic gaps (affluent *vs.* poor)
   e. Relationship with parents: dependence/independence issues
   f. Responsibility: fear of failure, fear of success
   g. Academic stress
   h. Expectations of sexual role (male/female)
3. PROBLEMS TO REDUCE OR ELIMINATE:
   a. Dropouts
   b. Absenteeism
   c. "Acting out" behavior in classrooms
   d. Academic failure and underachievement
   e. Amount of change-induced anxiety
   f. Maladaptation in peer and authority relationship problems
   g. Anxiety in transition from senior year of high school to college or work
   h. Number of "run-aways" from home
4. PROVISIONAL WORKING OBJECTIVES:
   a. Higher academic achievement
   b. Fewer dropouts

c. Higher employment rates
d. Fewer suspensions
e. Less absenteeism
f. Fewer pregnancies
g. Fewer family court referrals (if data available)

5. PROGRAMS:
   a. Stress Management
      (1) Decrease amount of class changing in seventh grade
      (2) Mutual support group of parents in late sixth grade
   b. Stress Resistance Building
      (1) Orientation to new school and new teachers while in sixth grade
      (2) Anticipatory guidance groups of sixth graders led by teachers, with topics spaced during sixth grade year, including normal physical development, feelings normally occurring during transitions, and "Transition Management," e.g., job changes, decisionmaking, use of role playing and models with this program
      (3) Teacher groups (seventh grade teachers) on "Helping Young Persons Deal with Transitions and Cope with Disappointments"
   c. Stress Reaction Management
      (1) Peer tutoring
6. COMMUNITY INSTITUTIONS TO BE INVOLVED:
   a. Superintendent
   b. Board of Education
   c. Senior school administrators
   d. Principal
   e. Teachers
   f. Parents/PTA/"Opposition" parent groups
7. STEPS TO SECURE INTEREST AND COOPERATION OF COMMUNITY GROUPS:
   a. Face-to-face contact between Director of CMHC and Superintendent of Schools (assuming Director of CMHC has supportive data and willingness to receive additional input from Superintendent)
   b. Linkages to be established with appropriate senior administrators; communication channels developed to receive input from school officials in order to arrive at a collaborative effort for the final program
   c. Group meetings with teachers and parents
8. PROGRAM OUTLINE:
   a. Early to mid-sixth grade: Group discussions with students to deal with issues of physical changes, emotional reactions, importance of peer group in regular classroom setting

b. Late sixth grade: Mutual support group for parents dealing with issues of early adolescent development and reactions to change
c. Late sixth grade: Discussion groups of sixth graders on "Transition Management" including: normal reactions to change; handling job changes and school changes; decision-making skills, use of modeling and role playing (involving seventh and eighth graders)
d. Mutual support group of seventh grade teachers: "Helping Young People Deal with Transitions and Disappointments"
e. Use of peer tutoring, where possible, throughout sixth grade

9. EVALUATION:
   a. During the first year
      (1) Academic performance
      (2) Dropouts
      (3) Impressionistic data from administrators, teacher, students
      (4) Amount of student participation in group discussions
      (5) Data from seventh grade teachers on "How are transitions going?"
   b. Followup data
      (1) Subsequent dropout rates
      (2) Absenteeism
      (3) Academic performance
      (4) Employment rates after senior high school
      (5) Police/family court data
10. FINANCIAL CONSIDERATIONS:
   a. Initially, CMHC assumes major cost
      (1) Program requires two CMHC staff persons for planning, entry, and training negotiations
   b. Joint planning of CMHC and school district may lead to grant proposal to secure future funding
   c. Hopefully, skills will be built into school system as program goes on so that teachers will assume training and group leader roles

OUTLINE PLAN — WORK GROUP F

POPULATION AT RISK: SINGLE PARENTS RAISING MINOR CHILDREN

1. MAJOR STRESSES:
   a. Practical problems: financial, legal, living arrangements, child care, employment, emergency resources, maintenance
   b. New role identity: heterosexual relationships, sexuality, parental role changes, singles in a couple-oriented society, social stigma
   c. Need for new peer group
   d. Emotional: anger, guilt, sense of failure, lack of direction, loneliness, sense of unique isolation, self-pity
2. PROBLEMS TO REDUCE OR ELIMINATE:
   a. Isolation — physical and emotional
   b. Practical problems listed above
3. PROVISIONAL WORKING OBJECTIVES:
   a. Founding of mutual support groups
4. PROGRAMS:
   a. Stress Management
      (1) Structured educational programs around practical problems
      (2) Group family activities
      (3) Community resource information
   b. Stress Avoidance
      (1) Child care exchange (short-term) for parent relaxation and relief in emergencies
      (2) Adult social activities
   c. Stress-Resistance Building
      (1) Awareness Groups
      (2) Informal moderated discussions
   d. Stress Reaction Management
      (1) Buddy system
      (2) Professional referrals
5. COMMUNITY INSTITUTIONS TO BE INVOLVED:
   a. Churches
   b. Family Service Agency

c. Day Care Centers
d. Lawyers
e. YM/YWCA
f. Media for publicity
g. PTA and school newsletters

6. STEPS TO SECURE INTEREST AND COOPERATION OF COMMUNITY GROUPS:
   a. Form small core group of single parents to reach out to community groups
      (1) One vehicle — a speakers' service
      (2) Primary means — person-to-person contacts
7. PROGRAM OUTLINE:
   a. Core group plans and forms larger group
   b. Activities grow out of chief needs of members — cannot be prescribed by professionals in advance
   c. Leadership training for group leaders; discussion group leaders may be provided by CMHC
8. EVALUATION:
   a. Evaluate whether needs of community subgroups (widowed, differing age groups, ethnics, economic, geographic) are met through participation; consider if new groups are needed
   b. Survey of members after 6 months
      (1) Followup on reasons for dropouts
      (2) Numbers of new members in relation to population in need
9. FINANCIAL CONSIDERATIONS:
   a. Initial seed money — $50 to $100
      (1) Membership fees
      (2) Fund-raising activities by members
      (3) Contributions from local churches, NASW chapter, etc.

OUTLINE PLAN — WORK GROUP P

POPULATION AT RISK: NEWBORN INFANTS AND THEIR MOTHERS

1. TARGET POPULATION: Newborn infants (0 to 1 year) and their mothers (the focus is on the mother/child relationship following birth; primary prevention issues prior to birth have not been addressed)
2. MAJOR STRESSES:
   Mother/child relationship:
   - Overdemanding infant
   - Overprotection
   - Rejection — abuse, neglect
   - Physical and developmental disabilities (grief reactions)
   - Failure to thrive
3. PROBLEMS TO REDUCE OR ELIMINATE:
   a. Rejection
   b. Overprotection
   c. Grief-loss reactions
   d. Consequences of developmental disabilities
   e. Abuse — neglect
4. PROVISIONAL WORKING OBJECTIVES:
   Pilot project in one or two community hospitals to reach all newborns during a 1-year period
5. PROGRAMS:
   a. Stress Management
      (1) Hospital interference in mother/child relationship
      (2) Mother's response to child — anxious, depressed, hostile, unfeeling, unsure, etc.
   b. Stress Avoidance
      (1) Substitute mothers — foster grandparents, future mothers
      (2) Mother retreat facilities — where mothers can "get away from it all"
   c. Stress-Resistance Building
      (1) Infant stimulation and structure
      (2) Counseling in groups (self-help groups) which might include a support figure to assist the isolated nuclear family

d. Stress Reaction Management
   (1) Help for the mother to deal with her expectations, handling of special needs, reaction to disabilities, etc.

6. COMMUNITY INSTITUTIONS TO BE INVOLVED:
   a. Community hospitals: pediatric nurses, pediatricians, hospital auxiliary
   b. County medical society; public health agents
   c. Easter Seal Society, Association for Retarded Citizens, Child Welfare
   d. La Leche League
7. STEPS TO SECURE INTEREST AND COOPERATION OF COMMUNITY GROUPS:
   a. Community organization efforts — planning, funding
   b. Community education — problem and solutions
   c. Epidemiological study — the extent and nature of the problem
8. PROGRAM OUTLINE:
   a. Through community hospitals and hospital auxiliary to establish monthly or biweekly mother/infant groups to explore feelings, etc.
   b. To provide consultation and referral services by CMHC staff to high-risk members of groups, to community resources for counseling, infant stimulation, foster grandparents, etc.
9. EVALUATION:
   a. Commitment of resources; attendance of mothers; responses of participants; response of community agencies to referrals from the groups
   b. Attendance of participants; pretest and posttest (at 3 months and 1 year) of those participating and control group (those not attending but completing instrument at time of birth)
10. FINANCIAL CONSIDERATIONS:
   a. Staffing: one-fourth time project director and one-half time pediatric nurse
   b. Source of funding: local foundation; hospital expected to continue project if shown to be effective

Chapter VI
CONFERENCE EVALUATION

CONFERENCE EVALUATION

A major objective of this pilot effort was to test out a conference model and to determine its relative merits and drawbacks. Accordingly, conference assessment was approached from several perspectives:

(1) the extent to which the expectations of the participants were met
(2) the extent to which participants' attitudes toward primary prevention were changed
(3) the degree of overall satisfaction with the conference, as measured at the closing session
(4) participants' assessment of specific components of the conference content and design
(5) followup appraisal of the conference impact on participants' work in their own agencies

Evaluation of the conference impact and design elements was carried out by means of questionnaires administered immediately before and after the meetings, by group interviews on the final afternoon, and by a letter to each participant 3 weeks after the conference asking for data regarding steps taken or plans made as a result of attending. The questionnaires, group interview schedule, and followup inquiry are included in appendixes K, L, M, N, and O.

Pre-Conference Expectations

As the conference began, each participant was asked to list "the expectations you have of this conference . . . what specifically do you want to take away from this experience?" From the responses, a list of 35 items was obtained that covered a wide range of possible outcomes. At the close of the conference, participants were given the list of 35 expectations and were asked to indicate those goals which were not relevant to them and to rate the extent to which each relevant goal was met. The scale used was "not met" (given a score of 1), "met" (scored 2), and "more than met" (scored 3). Thus a rating of 1.9 or over is taken as a clear indication that for those participants for whom the goal was relevant it was met or exceeded.

Before results were analyzed, 16 goal statements ("Key Goals") were identified which were deemed to be especially consistent with the objectives of conference planners. Fourteen goals were listed as relevant by 90 percent or more of the participants ("Relevant Goals"). The following table indicates the goal attainment scores of 23 items and notes whether each was a Key Goal, a Relevant Goal, or both:

Goal or expectation considered key or relevant	Key goal	Relevant goal	Attainment score
Meet others in the field		X	2.57
Renew my enthusiasm for primary prevention work	X		2.41
Get information about others' efforts		X	2.36
Learn about new program ideas		X	2.25
Get to know resource people for future reference	X	X	2.22
Exchange ideas with other communities	X	X	2.19
Re-evaluate my own ideas	X	X	2.14
Develop stimulating contacts with nearby programs	X		2.07
Do some planning with members of my CMHC team here	X		2.00
Learn how to get prevention programs started	X		2.00
Explore strategies for developing preventive programs	X	X	1.98
Learn about techniques and strategies		X	1.94
Learn how to set realistic goals for preventive effort	X	X	1.90
Learn ways to stimulate self-support groups		X	1.83
Learn about sources of ongoing future information	X	X	1.81
Get help in developing our prevention programs	X		1.79
Develop specific plans for prevention in our community	X		1.79
To learn about doable programs with limited resources	X	X	1.76
Learn more about evaluating preventive programs		X	1.67

continued

Goal or expectation considered key or relevant	Key goal	Relevant goal	Attainment score
Examine effectiveness of different models		X	1.66
Explore ways to manage primary prevention programs	X		1.61
Develop strategies for "selling" prevention to my Director	X		1.46
Learn how to interest clinical staff in primary prevention	X		1.35

Using the mean rating of 1.90 as the dividing line, the following table sets forth the number and percentage of goals judged to be "met" (a mean rating of 1.9 or above) or "not met" (a mean rating of below 1.9):

Category of goals	"Not met" Below 1.90		"Met" 1.90 and Above	
	No.	%	No.	%
Total goals (35 items)	19	54	16	46
Key goals (16 items)	7	44	9	56
Relevant goals (14 items)	5	36	9	64
Both key and relevant combined (7 items)	2	28	5	72

Using the relatively stringent criterion of 1.9 as described above, almost half of the 35 objectives brought by participants were realized. Moreover, over half of those considered "key" by the planners or especially "relevant" by most participants were met. Almost three-fourths of the seven objectives deemed "key" by planners and "relevant" by over 90 percent of the participants were achieved. While no statistical test was made to determine whether the percent of goal attainment differs significantly from what might have been expected by chance, it seems apparent that the conference had a significant impact in terms of the participants' satisfaction with the extent to which their objectives were met.

Conference goals appear generally to have been consistent with those of the participants. In the preconference evaluation, conferees were asked to indicate for each of five goals whether or not it was relevant to them and, if so, the degree of importance. Only one participant indicated that one of the conference goals was not relevant to him. The following table indicates the mean rating of importance attached to each objective by participants:

Objectives With reference to Primary Prevention, to increase:	Not relevant (0)	Slight importance (1)	Fairly important (2)	Very important (3)	Extremely important (4)
1. Familiarity with program strategies	0	1	2	3 X^1	4
2. Understanding of approaches to evaluation	0	1	2	3X^1	4
3. Related activities at participating mental health centers	0	1	2 X^1	3	4
4. Ability to identify and intervene with "at risk" target groups	0	1	2	3 X^1	4
5. Ability to set priorities among possible target groups	0	1	2	3 X^1	4

X^1 = mean rating of all conference participants

Attitudes Toward Primary Prevention

The impact on participants' attitudes toward primary prevention was assessed in three different ways:

(1) Pre- and postconference comparisons were made of ratings by participants of the importance of three possible primary prevention activities. However, the comparisons were not useful for evaluative purposes because the mean ratings of the three items at the preconference point were so high as to rule out the likelihood of significant change. The pre- and postconference mean ratings are given in the following table using a five-point scale (1 = not important; 5 = essential):

Items: Possible activity of a community mental health program	Mean ratings	
	Pre-	Post-
Psychological education of young children to help prevent behavior problems	4.1	4.3
Educational and support services for mothers of newborn infants	4.0	4.0
Mutual help support groups for newly widowed persons	3.7	3.7

(2) Pre- and postconference comparisons also were made of responses to the following question: "Ideally, what percent of staff time would you like to have devoted to primary prevention pro-

graming (in your center if you're a staff or board member; in the average center if not)." Mean preconference response was 27.5 percent; mean postconference response showed a modest increase in favor of primary prevention programing to 28.2 percent.

(3) A clear indication of the impact of the conference as experienced subjectively by participants is given in their postconference ratings of "degree of change" experienced in each of six areas. The mean ratings of change are given in the following table (rating of 0 = "greatly decreased"; 5 = "no change"; and 10 = "greatly increased"):

Areas of possible change	Mean rating of change
1. Familiarity with program strategies in primary prevention	8.2
2. Understanding of approaches to evaluation of primary prevention programs	7.5
3. Interest in having primary prevention programing increased at our center (or centers generally)	8.3
4. Ability to identify and intervene with "at risk" target groups	7.3
5. Ability to set priorities among possible target groups	6.6
6. Commitment to increased primary prevention even if more funds are not available	7.5

Participants experienced considerable increases in all six areas, with the greatest change related to having primary prevention programing increased at the local CMHC level, the major interest of conference planners.

Overall Satisfaction

Two measures of overall satisfaction with the conference were included: (1) the dollar value of the experience in terms of a fee which participants would have paid or would have recommended that their agencies pay; (2) a comparative rating of the conference on a scale between the best and worst conferences ever attended.

Item: If a registration fee had been required for this conference:

A. In light of your experience, what fee would you personally have been willing to pay?

Mean = $42.50
Range = 0 to $100.00
SD = $25.00

B. What fee would you recommend your agency should have been willing to pay in terms of the value of the conference to local community mental health centers?

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Mean = $68.02
Range = 0 to $200.00
SD = $44.00

Item: Think of the worst conference you ever attended and rate it zero (0) on the following scale; think of the best conference you ever attended and rate it ten (10). Then consider how you would rate this conference. Please put an x on the scale at the point which relates to the worst and best conferences you've attended.

Mean = 7.9
Range = 3 to 10
SD = 1.4

	Worst									Best
Distribution of ratings:	1	2	3 (N=1)	4 (N=1)	5	6 (N=4)	7 (N=11)	8 (N=16)	9 (N=13)	10 (N=5)

Evaluation of Conference Components

In order to obtain guidance about the design of future conferences, participants were asked to rate on a four-point scale how helpful each component was in terms of its value to them and their efforts in community mental health. In no instance was a component rated on the average below the "somewhat helpful" level. The results are summarized in tabular form:

COMPONENTS OF THE CONFERENCE

FRIDAY			Not helpful 1	Somewhat helpful 2	Helpful 3	Very helpful 4
		A. Presentation and discussion of data from preconference survey	1	2 X[1]	3	4
		B. Presentation: "An Overview of Primary Prevention Programing" (Goldston)	1	2	3X[1]	4
Number responding	Mean response	C. Concurrent Workshops I: Primary Prevention for Specific Target Groups	1	2 X[1]	3	4
9	3.1	1. Programs for Newborn Infants (Broussard)				
20	2.0	2. Affective Education With School Age Children (Hartley)				
12	2.7	3. Mutual Help Groups for Widows (Silverman)				
11	3.3	4. Cognitive Education of Preschoolers (Spivack and Shure)				

continued

SATURDAY			Not helpful 1	Somewhat helpful 2	Helpful 3	Very helpful 4
Number responding	Mean response	D. Concurrent Workshops II: Agency Strategies for Primary Prevention	1	2	3 X[1]	4
16	3.6	1. Epidemiological Approach (Bloom)				
15	3.7	2. Programs With Disadvantaged Community Groups (Paster)				
9	3.3	3. Cultivating Personal and Leadership Skills in the Community (Raber)				
14	3.3	4. Programs With Major Community Institutions (Santos)				
		E. Presentation: "Basic Strategies in Designing Primary Programs" (Hollister)	1	2	3 X[1]	4
		F. Mini-workshops on Strategies	1	2 X[1]	3	4
		G. Presentation: "Evaluating Achievable Objectives for Primary Prevention" (Bloom)	1	2	3 X[1]	4
		H. Work Groups: Work on Outlining Plans for "At Risk" Target Group	1	2 X[1]	3	4
Number responding	Mean response	I. Concurrent Workshops III: Aspects of Prevention	1	2 X[1]	3	4
9	2.4	1. Funding (Baxter)				
7	2.9	2. Involvement of the Community (Raber)				
6	2.1	3. Evaluation (Lauterbach)				
4	2.0	4. Management (Hollister)				
SUNDAY						
		J. Project Response Panel Reviewing and Discussing Sample Work Group Reports	1	2 X[1]	3	4
		K. CMHC Teams: Developing Work Plans for Own Localities	1	2 X[1]	3	4
		L. Clinic Clusters: CMHCs within Geographic Areas Consult on Each Other's Plans	1	2 X[1]	3	4
		M. Final General Session with Resource Panel	1	2X[1]	3	4

X[1] = mean rating of all conference participants

To assist further in the planning of possible future conferences, participants were asked to suggest improvements and indicate what elements should be maintained in the following areas: selection and recruitment of participants, preconference materials, conference location and facilities, logistical support, staffing, content, design and procedures, and conference evaluation. Briefly noted, the responses indicated that:

(1) The conference had been for most everyone a highly involving, exhausting, yet rewarding experience. Among the positives singled out for mention were: the balance of inputs and discussions; the staff's commitment to providing a high quality experience; well-run discussion groups and time for discussion following presentation; the report back on the preconference survey; the work group experience; maintaining the schedule; the grouping by interests; the choice of several options within the workshops; and the major presentations.

(2) The participant team concept should be maintained and, if possible, more effective measures should be devised for ensuring the attendance of agency administrators and board members.

(3) Preconference materials were considered to be very helpful. Suggestions for consideration included: a case book of typical preventive programs with rationale and analyses, reading references to material on the public health prevention model and on primary prevention in mental health, material relevant to the content of general sessions (i.e., papers mailed out in advance), and a format for developing problem statements to be worked on at the conference.

(4) Conference site and facilities were considered superb.

(5) The backup support provided by administrative staff was singled out for special mention; many commented on the easy access to printed materials in the resource room and were impressed by the volume and quantity of the materials. The use of audiovisual materials, including easels available for each work group, was appreciated.

(6) Participants responded enthusiastically to the calibre, mix, enthusiasm, and accessibility of faculty, with but one exception.

(7) Participants generally were satisfied with the content covered. Several persons noted that workshop titles were somewhat misleading, e.g., the one on "Primary Prevention With Major Institutions" focused solely on public schools and the one on "Affective Education" did not concern itself with the kind of psychological education in the schools that today is labeled "affective." Several participants suggested that the input on evaluation include more concrete examples of how assessment of programs had been carried out and with what results. Another suggestion was that the material on funding include a more specific listing of new funding possibilities.

(8) It was generally agreed that the experience was intensive, with too little time for rest, reflection, or informal discussion with fellow participants and faculty. Reactions to the pacing varied; the range is best expressed by the following two quotes (both from persons who rated the experience highly):

> Slow down! My God, I feel the need of a 'care' person to alleviate the stress generated by the pace!
>
> It was designed to give us the most in the least time with time to begin the seeds of many new things!

Most participants recommended that more free time be built into the schedule to permit rest and reflection, reading, and informal discussions. Suggestions varied about how to accomplish this goal. Some suggested adding at least 1 day. Others recommended eliminating one set of workshops. A few thought the work group time could be consolidated and advised against interrupting with workshop options. Several were adamant about eliminating at least one evening work period or shortening the evening periods. It was pointed out that participation slacked off at the Saturday evening work group session and that the following day's sessions seemed to be affected by fatigue and a reduced level of involvement.

(9) Few specific suggestions were made about evaluation procedures; most participants indicated that approaches used should be maintained.

(10) A sampling of comments from those who added spontaneous inputs in areas not outlined in the questionnaire gives further indications of participant reactions:

> Keep the constant availability of printed materials, speeches, work group products, etc. Terrific!
>
> Exhausting but exciting. I ended up with a feeling of accomplishment and education—not a hot social time at the MHC's expense.
>
> Irrelevant at this time. (Most negative comment of all.)
>
> As a man from the sticks, it was nice to see actual warm, sensitive people from NIMH and MHA.
>
> I would evaluate the conference as a good one with some qualifications. The highly structured design . . . minimized the excitement and stimulation which I would like to carry away with me . . . More opportunity to exchange ideas with my newly met colleagues generates the kind of excitement to which I am referring.
>
> Encourage participants to share their materials with other groups and agencies back home.
>
> In general, this was an excellent, well-planned, stimulating, and helpful conference. I appreciated the opportunity to attend.
>
> Logistically superb.
>
> My first conference in the CMHC system; it was excellent.

Followup Appraisal

A simple, relatively open-ended followup inquiry was mailed to participants 3 weeks after the conference in order to gain some impressions about whether and how the experience was contributing to functioning of CMHC board and staff members. The Followup Evaluation Form is included in appendix O. Thirty-one responses were received (about a 50 percent return). The replies generally indicated that the experience had had both personal and agency impact. Possibly, people for whom the conference had not had impact might not have responded; therefore, the results of this inquiry should be interpreted cautiously.

Four responses were received from CMHC directors. In each instance, the conference was described as having considerable impact. One executive has convened a staff planning committee for primary prevention programing and for coordinating the agency's consultative services. Another has found himself responding more enthusiastically to the priority needs expressed by his C & E director. A third stated: "I am a convert now. I have found myself more committed and convincing in reporting to my staff on the conference."

Program development or modification activities are in the planning stages at several agencies. These proposed efforts included incorporating C & E within a new Division of Community Services with a mission greatly expanded beyond the prior C & E coverage, developing a priority emphasis on mutual support groups on a community-wide basis, negotiating a specific primary prevention program for reducing stress among incoming college freshmen, implementing a total school mental health program based on the model presented at the conference by Santos, redefining and expanding an existing peer counseling program, and establishing a collaborative effort with primary prevention programers in other agencies to develop a comprehensive program for an entire metropolitan area.

Responses received from seven board members indicated that, with one exception, each had become a more enthusiastic advocate of primary prevention within the agency. One board member had persuaded the advisory board to begin a study of moving the CMHC from the local general hospital into the community "where community mental health programs can be developed." Another had suggested a joint committee of board, staff, and administration to design and implement one small primary prevention program as an initial undertaking. Another reported that his agency had already established specific goals for C & E work and had placed a 6-month deadline on evaluation of progress toward those goals; in the same agency, steps were underway to form a committee of concerned citizens to support primary prevention activities.

Staff members, especially those responsible for C & E activities, reported that the conference had been highly educational, energizing, and supportive. A number of instances were cited where specific techniques and models were being applied in program development or redesign. In one way or another, most of the participants indicated that the enthusiasm and conviction of other participants had helped them feel less isolated in their ideas and priorities.

At several agencies mini-workshops and conferences were being planned for staff members, advisory boards, and community groups to acquaint them with the conference and discuss implications for the local scene.

In general, these responses—with one or two exceptions—confirmed the value of the conference both as a vehicle for personal learning and as a way of helping the participants stimulate and focus energies toward primary prevention work within their own settings.

Chapter VII
RECOMMENDATIONS

RECOMMENDATIONS

The first objective of the project appears to have been realized — a workable, high-impact design for a model Conference on Primary Prevention has been developed and tested. With minor modifications based on the pilot experience, the model appears to be adaptable to other locations in the United States. Judging from the evidence available, the conference approach has the capacity to mobilize increased interest in and the ability to promulgate primary prevention programing within local CMHCs, especially when coupled with the support of State and Federal mental health authorities as well as local, State, and national mental health organizations. Moreover, the interest expressed in the pilot conference by mental health professionals and interested citizens around the country suggests that regional conferences on primary prevention would be well received in many metropolitan localities.

Therefore, the following recommendations are offered on the basis of the entire conference project experience:

I. Five regional conferences should be held within the next 12 to 24 months. Interest in primary prevention is growing within local CMHCs and community groups. The time seems right for a series of highly visible activities that would engage directly local leaders within the mental health field and would enlist indirectly the interest and attention of many others. Five conferences would encompass most of the major concentrations of federally funded and other mental health programs and would serve to maintain a momentum of interest and involvement within the national organizations most directly involved—namely, the National Council of Community Mental Health Centers, NIMH, and NAMH.

II. Additional regional conferences should utilize the essential elements of the pilot conference in a modified design. Such conferences would:

(1) focus on primary prevention as a broader concern for consultation and education activities generally;

(2) be designed primarily for teams of decisionmakers within local CMHCs, including agency directors and one or two board members;

(3) provide concrete examples of well-evaluated and successful primary prevention programs;
(4) include a major emphasis on epidemiologic and other population-wide approaches to primary prevention programing;
(5) provide substantive inputs on the state-of-the-art of primary prevention, program strategies, and approaches to evaluation;
(6) engage participants in a learning experience designed to help them apply primary prevention programing concepts and techniques for designated "at risk" target groups;
(7) give access to national experts in the field;
(8) involve local faculty resource persons wherever possible to ensure readily available consultation following the conference;
(9) provide a kit of written take-home materials developed both by conference faculty and participants during the conference; and
(10) involve prospective participants prior to the conference by means of a survey on possibilities and problems with respect to primary prevention.

Regional conferences would enable participants to meet and exchange ideas, experiences, and resources with colleagues from nearby CMHCs, thus increasing the likelihood of creating a critical mass of interest and expertise within each target area.

III. On the basis of the pilot experience, certain minor modifications in conference design are suggested. The changes are intended to afford more time for informal use of onsite resources, to reduce overall conference intensity, and to maintain a high level of participant involvement through the closing session.

One change involves the consolidation of the first two sets of concurrent workshops into a single set of three-to-five simultaneous offerings focused on programs for target populations and agency strategies for primary prevention. Preceding the workshops would be a general session devoted to a well-evaluated model effort. This showcase presentation would be followed by participant discussion to be guided by a framework for primary prevention programing given to conferees in advance.

The Project Response Panel which provided a focal point for discussion of selected work group products is eliminated. Work group products would continue to be reproduced and shared with all participants. Planning for

local application of the conference experience would follow completion of the work groups. If feasible, the team meetings would contribute to sharing of ideas and concerns within clusters of mental health programs in a geographic region.

The culminating experience of the conference would be a presentation by a national expert focusing attention on new directions for primary prevention based on his/her analysis of current research related to programing in this area.

Selection of conference locations should be based on several criteria: the existence of an adequate number of CMHCs within a target region (possibly more than 30), the possibility of linking conference sponsorship with a regional training or manpower development resource (such as SREB in the Southeast), and the interest of Federal regional office mental health staff members in becoming involved with such a venture.

The specific sequence and timing of conference components will depend in each instance on local needs and concerns, the requirements of the physical setting, the days chosen for the event, and the specific talents of the conference faculty. The format shown on page 144 illustrates one way in which the suggested modifications can be incorporated into a specific conference design.

IV. Replication of the conference model should be handled as a national effort coordinated by a single organization capable and interested in linking each conference, where possible, to appropriate local and regional groupings and organizations. Centralized coordination is recommended in order to:

(1) maintain the integrity of a conference design which has been shown to be highly successful

(2) enable conference planners and staff members to improve the model based on each successive experience

(3) maintain the clarity of purpose and focus on primary prevention

(4) facilitate the development of materials which can be tested within successive conferences and ultimately be made widely available

(5) hasten a process leading toward: the development of a national resource bank for primary prevention, national visibility of primary prevention activities, and wider training and consultation services for mental health programs wishing to implement preventive services

The National Council of Community Mental Health Centers, which served as a cosponsor of the pilot confer-

Sample Format of Modified Conference Design

	Day 1	Day 2	Day 3
Morning		8:45-10:15 GENERAL SESSION: Presentation and analysis of case example of primary prevention 10:45-12:30 3 to 5 concurrent workshops on "Targets & Strategies: Case Examples"	8:45-9:45 GENERAL SESSION: Presentation on "Evaluating Achievable Objectives for Primary Prevention" 9:45-12:30 WORK GROUPS: Develop outline plans for preventive programs with designated target groups
Afternoon	REGISTRATION	2:00-3:00 GENERAL SESSION: Presentation on "Strategies for Primary Prevention" 3:30-4:30 WORK GROUPS: Practice in applying strategies 4:30 FREE TIME (resource room open)	2:00-3:00 WORK GROUPS (Cont.) 3:00-4:30 CMHC TEAM MEETINGS: Outline plans for back home 4:30-5:30 REGIONAL CLUSTERS: CMHC teams share and critique plans; consider possibilities for mutual aid
Evening	7:00-9:30 GENERAL SESSION: –Report of Preconference Survey –Exploration of Issues –Presentation on "Overview of Primary Prevention"	7:00-9:30 OPTIONAL WORK SESSIONS (resource room open) Special Interest Groups (e.g., on funding, evaluation, management, community involvement; or by roles and functions, e.g., Directors, Board Members, C & E)	6:00 DINNER MEETING: Presentation on "New Directions for Primary Prevention" 8:00 ADJOURN

ence, has expressed interest in the possibility of becoming the focal point for succeeding conferences. NCCMHC appears to be the appropriate organization to undertake the recommended effort in view of its national membership of local CMHCs and its linkages to State and metropolitan groupings of mental health programs.

Though the National Association for Mental Health would not be the applicant for a contract to manage subsequent conferences, the NAMH is prepared to maintain liaison with the planning of conferences on a national level and, through its divisions and chapters, remain involved in the conferences and in subsequent contacts with local mental health programs. The NAMH would emphasize continuing support of these conferences as a mechanism for encouraging primary prevention through the potential catalytic role of its chapters vis-a-vis service providers, other groups of interested citizens, and non-mental health professionals.

V. Each conference should be developed in consultation with appropriate citizen and professional groups in each region. Mental health associations, organizations and federations of mental health programs, State mental health authorities, and Federal regional office mental health staff members are among the key groups to be contacted in any such effort.

In each target area, a local coordinator should be hired to establish the needed linkages to local resources, engage the active interest and cooperation of local groups, recruit nearby faculty to augment a national core resource team, identify an appropriate conference site, and make arrangements for needed equipment and support staff.

The pilot experience reveals that mental health programming relevant to primary prevention is undertaken by a variety of agencies and organizations of which not all are federally funded and only some are affiliated with NCCMHC. Therefore, considerable effort will need to be made to ensure the widest possible involvement of community mental health delivery systems for which primary prevention would be feasible; local coordinators and linkages to local groups should help to secure the interest of all such programs.

VI. Successive conferences should be conducted in the context of related efforts to ensure a continuing focus of energy and resources at the local level after the conference has been held. Linkages to training and manpower development or coordination of centers (such as SREB) have already been stressed. University training centers and schools of public health may be additional groups that can be counted on to provide long-range assistance in the form of consultation and technical assistance as well as, in some cases, local workshops for CMHC staff teams, board members, and representatives of key human service organizations.

Other ideas for stimulating continuing effort which emerged in the course of the pilot effort include:

(1) providing funds to conference participants who devise feasible experimental ideas for program development in primary prevention as a conference sequel to help seed the initial stages of the new effort;

(2) establishing a national pool of consultants and technical experts in primary prevention;

(3) developing written and audiovisual materials and workshop designs for use by conference participants wishing to educate their local colleagues to basic concepts and techniques of primary prevention;

(4) providing small grants for mini-conferences in metropolitan settings as a way to disseminate conference learnings to local CMHC boards and staff members, to relevant agencies, and to civic leaders; and

(5) developing a central clearinghouse (possibly in conjunction with the National Clearinghouse for Mental Health Information at NIMH) for materials, program ideas, and literature pertaining to primary prevention.

VII. Consideration should be given to establishing a modest fee for individual or agency participation in future conferences, primarily to increase the likelihood that a commitment to attend will be honored by agency directors and policymakers. About two-thirds of the participants at the pilot conference would have been willing to pay personally from $18 to $68 if a registration fee had been required. Therefore, a charge should be set at no less than $25 and no more than $50 per participant.

VIII. The experience with the pilot conference has demonstrated that considerable interest prevails about primary prevention within local mental health programs. The time seems especially favorable for a consistent effort to develop and evaluate carefully designed and sustained programs applicable to designated high-risk target groups and to test alternative models for involvement of community groups in coordinated thrusts to reduce the incidence of specified disablements.

A national posture regarding primary prevention in mental health is needed at this juncture to capitalize on a remarkable readiness. This posture would be reflected in program priorities, manpower development, increased attention to evaluation skills, dissemination of findings and promising techniques, the encouragement of experimentation with models for administering primary prevention programs in relation to other mental health activities, and

increased emphasis on the public health, population-oriented approach within community mental health.

The recommended replication of the pilot conference would serve as an important means to provide essential impetus toward assuming this national posture. The time seems right; the interest is high. A model has been created and tested.

APPENDIXES

Appendix A

DATA SHEET

October 1975

In cooperation with the National Council of Community Mental Health Centers, the National Association for Mental Health, under contract with NIMH, is developing a Pilot Conference on Primary Prevention for decisionmakers in the community mental health field. The Association plans to distribute to conferees representative examples of primary prevention activities which have been field tested with populations at risk. If you know of a project in your CMHC or elsewhere which you think may be relevant to the conference, please complete the following questionnaire by November 17, 1975.

NAME OF PROJECT (or brief identifying phrase):

LOCATION OF PROJECT:

Agency or program name:

Address:

Telephone number:

PROJECT DIRECTOR (or other person who can supply further information):

BRIEF DESCRIPTION OF PROJECT (e.g., goals, target population, methods, duration):

If the project has been written up in a professional or other publication, please indicate where:

Name of publication: _____

Date of publication: _____

Are unpublished reports available? Yes_____ No_____

(If you have a reprint or other description of the project, please enclose.)

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* Faculty members
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MEMORANDUM

March 15, 1976

TO: Participants, Pilot Conference on Primary Prevention

FROM: Don Klein, Project Director

SUBJECT: ORIENTATION TO THE CONFERENCE

WELCOME! We are very pleased that you are able to participate in this Pilot Conference on Primary Prevention and we are looking forward to a stimulating and productive experience together. This memo is to inform you regarding some elements of the Conference and some ideas as to how, together, we can assure a mutually successful program.

This conference has one overriding objective — to present a model program through which awareness and action on behalf of primary prevention in mental health can become a more effective force in our communities. The design for this model conference has been completed and you are a part of it. The conference design, however, is only an instrument — it now requires players. Within the design, we hope the players can find fulfillment for some of these sub-objectives:

- To become more informed about issues and programs regarding primary prevention in mental health
- To increase skill in developing primary prevention programs on behalf of a specific community target group
- To experience with colleagues both the giving and the acquiring of information, skill, and attitudes which support primary prevention in mental health
- To deepen commitment within self and a team of organizational colleagues to producing programs which can make a difference in one's own community on behalf of primary prevention in mental health

These objectives are highly mutual in nature and will require the application of energy from both conference staff and participants. The conference design attempts to present the staff as helpers and

resources rather than as authorities or experts. The design also assumes participants have a high degree of experience and resource with regard to improving community conditions for mental health.

This will be a working conference. The conference staff may be expected to be available throughout the duration of the conference in addition to the sessions for which their specific resources will be utilized. Conference participants will be expected to fully participate in all conference sessions and the various subgroup sessions also included in the conference design.

In this respect, you will be asked to participate in three types of subgroups:

- At the time of registration you will be asked to select two workshops which you choose to attend from among a listing of eight. The titles of these workshops are indicated elsewhere in the materials in this packet.
- Also at the time of registration, you will be asked to join a work group which will be asked to work together on behalf of a specific task associated with the conference objectives. That task will be identified in detail during the conference program.
- While in work groups, participants will be asked to identify one workshop among four that will be offered for them to attend. The work groups may develop criteria by which its members will attend these workshops.
- Toward the end of the conference, you will be asked to rejoin the team of colleagues attending the conference from your organization in order to complete the fulfillment of the conference objectives.

Because the conference design calls for several decisions from you which will directly affect both the substance with which you become involved and the people with whom you will work during the conference period, you are urged to review carefully the information which is included in this packet and which you will receive at the time of your arrival at the conference site so that you will be sufficiently informed to make decisions which you will regard as being in your best interest.

In addition to the availability of the resources indicated in the program for this conference, the design calls for the conference work groups to develop plans for primary prevention programs on behalf of specific target constituencies. These plans, products of the work groups, will be made available to you and all other participants prior to leaving the conference site. We expect that these plans will be found to be a rich resource for future reference by all in attendance.

There's a lot of ground to cover in primary prevention for mental health. This conference can't cover all of it, of course, but we expect to work hard at dealing with as much as possible in the time we have available. So, come with your ideas, high expectations, and a willingness to invest yourself and work hard. We look forward to seeing you on April 2nd.

[6] 16.3

CONFERENCE SCHEDULE

FRIDAY, APRIL 2

1:00–3:00 p.m. Registration

3:00–5:00 p.m. *Opening Session*

Convenor — Donald C. Klein, Ph.D., Project Director

Welcome — Mrs. J. Skelly Wright, Chairperson of Prevention Task Force, NAMH

Conference Overview — David Hartt, Ed.D., Conference Moderator

Presentation and Discussion of Data from Preconference Survey

Resource Panelists:

William G. Hollister, M.D.
Donald C. Klein, Ph.D.
Vera S. Paster, Ph.D.
Merrill F. Raber, M.S.W.

5:00–6:00 p.m. Social hour

6:00–7:00 p.m. Dinner

Comments by Frank M. Ochberg, M.D., NIMH

7:00–8:00 p.m. *General Session*

"An Overview of Primary Prevention Programing" — Stephen E. Goldston, Ed.D., M.S.P.H., NIMH

8:00–9:45 p.m. *Concurrent Workshops I:* Primary Prevention for Specific Target Groups

"Primary Prevention Programs for Newborn Infants at High Risk" — Elsie R. Broussard, M.D., Dr.P.H., University of Pittsburgh School of Public Health

"Preventive Outcomes of Affective Education With School Age Children" — Wynona S. Hartley, Ph.D., Department of Human Ecology, University of Kansas Medical Center

"Mutual Help Groups for Widows" — Phyllis R. Silverman, Ph.D., M.S.Hyg., Mystic Valley CMHC, Lexington, Mass.

"Preventively Oriented Cognitive Education of Pre-Schoolers"—George Spivack, Ph.D., and Myrna B. Shure, Ph.D., Hahnemann Medical College and Hospital of Philadelphia

9:45 p.m. — Hospitality suite open
Resource room open

SATURDAY, APRIL 3

8:45—10:15 a.m. *Concurrent Workshops — II:* Agency Strategies for Primary Prevention

"An Epidemiological Approach to Program Development for Primary Prevention" — Bernard L. Bloom, Ph.D., M.S.Hyg., Department of Psychology, University of Colorado

"Organizing Primary Prevention Programs with Disadvantaged Community Groups" — Vera S. Paster, Ph.D., New York City Bureau of Child Guidance

"An Approach for Cultivating Personal and Leadership Skills in the Community" — Merrill F. Raber, M.S.W., Growth Associates of Prairie View Mental Health Center, Newton, Kansas

"Developing Primary Prevention Programs with Major Community Institutions" — Robert R. Santos, M.S.W., Luzerne-Wyoming County Mental Health Center, Wilkes-Barre, Pennsylvania

10:15—10:30 a.m. Coffee break

10:30—12:30 p.m. *General Session*

"Basic Strategies in Designing Primary Prevention Programs" — William G. Hollister, M.D., Department of Psychiatry, University of North Carolina Medical School

Mini-Workshops — Practice on strategies

12:45—1:45 p.m. Lunch

1:45—2:30 p.m. *General Session*

"Evaluating Achievable Objectives for Primary Prevention" — Bernard L. Bloom, Ph.D., M.S. Hyg.

2:30—3:45 p.m. *Work Groups* — Teams of participants, with staff consultation, outline plans for primary prevention programing for designated "at risk" target groups

3:45—4:00 p.m. Break

4:00—5:30 p.m. *Concurrent Workshops — III:* Aspects of Prevention

"Funding — Who Pays When Nobody's Sick?" — Frances Z. Baxter, Community Mental Health Institute, NCCMHC

"Involvement of the Community in Primary Prevention" — Merrill F. Raber, M.S.W.

"Evaluation in Primary Prevention" — Walter Lauterbach, Ph.D., Division of Health Services, HEW Region III, Philadelphia

"The Management of Primary Prevention Programs" — William G. Hollister, M.D.

5:30—6:30 p.m. Free time: Resource room open

6:30—7:30 p.m. Dinner

7:30—9:45 p.m. *Work Groups (cont.)* — Groups complete outline plans on ditto masters for distribution Sunday morning

9:45 p.m. — Hospitality suite open
Resource room open

SUNDAY, APRIL 4

8:45—10:15 a.m. *General Session*

Review and analysis of sample work group reports with comments from Project Response Panel

Panelists:
Thomas F. A. Plaut, Ph.D., NIMH
John C. Wolfe, Ph.D., NCCMHC
Richard C. Hunter, NAMH

10:15—10:30 a.m. Coffee break

10:30—11:45 a.m. *Community Mental Health Center Teams* and other conferees — Develop work plans for primary prevention programing in their own localities

11:45—12:30 p.m. *Clinic Clusters* Groups of CMHCs within geographic areas assess and consult on CMHC work plans

Pittsburgh Area — Bernard L. Bloom and Frances Z. Baxter

	Philadelphia Area — Vera S. Paster and Stephen E. Goldston Other Pennsylvania — Merrill F. Raber and Walter Lauterbach Maryland and Delaware — William G. Hollister and Robert R. Santos NAMH group — John C. Wolfe and Wynona S. Hartley
12:30—1:15 p.m.	Lunch
1:15—1:45 p.m.	*Clinic Clusters (cont.)*
1:45—2:15 p.m.	*Evaluative Consultation in Clinic Clusters* — Participants consult with staff on improved design of future conferences
2:15—3:00 p.m.	*General Session* Final Exchange — Participants and Resource Panel Panelists: Bernard L. Bloom, Ph.D., M.S. Hyg. Vera S. Paster, Ph.D. William G. Hollister, M.D. Merrill F. Raber, M.S.W. John C. Wolfe, Ph.D.
3:00 p.m.	Adjourn

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1976

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Stephen Goldston, Ed.D., M.S.P.H.
Coordinator for Primary Prevention Programs
Division of Special Mental Health Programs

Vincent Mannino, Ph.D.
Mental Health Study Center
Division of Mental Health Service Programs

BIOGRAPHICAL SKETCHES of CONFERENCE FACULTY

Frances Z. Baxter

Fran Baxter is Director of Development for the new Community Mental Health Institute of the National Council of Community Mental Health Centers. She is responsible for soliciting financial support from foundations and industry, for developing educational programs for NCCMHC membership, and for providing ways in which the Council can provide needed informational, technical assistance, and other consultative services to local mental health centers. A graduate in sociology from the University of Delaware, she did postgraduate work in somatopsychology at the University of Houston under a fellowship from the Office of Vocational Rehabilitation. Before joining the staff of NCCMHC she was involved on the citizen side of the mental health movement, as Director of Training for the National Association for Mental Health and before that, as Executive Director of the Mental Health Association of Houston and Harris County (Texas). Her earliest professional involvement with mental health was as a teacher of emotionally disturbed children at the Delaware State Hospital.

Bernard L. Bloom, Ph.D., M.S. Hyg.

Bernie Bloom is a psychologist whose interest in primary prevention began after he had been a clinician for nearly a decade and had come to the conclusion that more resources should be allocated to prevention rather than to treatment. Having come to that conclusion, he left his clinical position and spent a year receiving specialized training in public health. Since 1962 his work, teaching, and research have all been directed to understanding ways of increasing the efficiency and effectiveness of mental health services and to developing strategies for the prevention of mental disorders.

Bernard L. Bloom (cont.)

Bernie is one of the founding members of the Division of Community Psychology within the American Psychological Association. He is a prolific writer in the field of mental health and prevention, having published more than 60 papers, two books, and a monograph. He is currently completing a textbook on community mental health.

Elsie R. Broussard, M.D., Dr. P.H.

Elsie Broussard is a leader in the mental health aspects of public health and is associated with several institutions in the Pittsburgh area. She is Professor of Public Health Psychiatry and Head of the Community Mental Health Program of the Graduate School of Public Health; Associate Professor of Child Psychiatry in the School of Medicine; and member of the staff of Western Psychiatric Institute and Clinic, University of Pittsburgh. She is also an Associate in the Pittsburgh Psychoanalytic Institute.

She received her Medical Degree from the Louisiana State University School of Medicine and her Doctor of Public Health Degree from the Graduate School of Public Health, University of Pittsburgh. She is certified as a diplomate of the American Board of Preventive Medicine in Public Health and by the American Board of Psychiatry and Neurology in Psychiatry and Child Psychiatry.

In 1973 she received the Lester N. Hofheimer Award from the American Psychiatric Association for outstanding research in mental hygiene in recognition of her longitudinal studies of first-borns.

Stephen E. Goldston, Ed.D., M.S.P.H.

Steve Goldston has been Coordinator for Primary Prevention Programs within the National Institute of Mental Health since 1972. He came to NIMH in 1961, having served previously with the Westchester County (NY) Community Mental Health Board, New York City Community Mental Health Board, and on the faculty of Columbia University. Shortly after joining NIMH as Assistant to the Associate Director for Extramural Programs, he functioned in an added capacity as staff, preparing working papers for President Kennedy's Interagency Committee on Mental Health, which formulated the new national community mental health program. Later he worked in the NIMH training grants program responsible for development of innovative experimental training programs, and projects in schools

Stephen E. Goldston (cont.)

of public health for promoting public health—mental health training. In 1967 he returned to the NIMH Director's Office as Special Assistant for Preventive Programs. His responsibilities within NIMH have brought him into close contact with most of the frontier programs of primary prevention in the United States.

David E. Hartl, Ed.D.

Dave Hartl is Director of the Office of Program Development and Assistant Director of the Conferences and Institutes Division, University of Maryland University College, College Park, Maryland. He has been consultant with many units of the Mental Health Association at the national, division, and chapter levels for over 6 years. He was educated at Boston University where he earned his doctorate in adult education and social psychology. Dave has held staff appointments in voluntary agencies and higher education institutions for nearly 15 years and has served on the faculties of the graduate programs in adult education at Boston University and the Johns Hopkins University. He is currently co-authoring a book titled *Continuing Education: Programing, Managing, Marketing* to be published by McGraw-Hill Book Company.

Wynona S. Hartley, Ph.D.

Wynona Hartley is a practical sociologist. An overriding interest in primary prevention and mental health outcomes surfaced early in her training when she organized a college course in sociology in terms of its preventive utility. Research in self-concepts and the definition of other social objects led her to the community mental health field. Her studies led her to become a senior research associate in the NIMH Epidemiologic Field Station in Kansas City. Her responsibilities there included a comparative evaluation of the impact of the Kansas City School Behavior Project, which was an experiment in preventive psychiatry. She carried this work with her when she moved to the University of Kansas Medical School where she is now located and received support from NIMH's Center for Epidemiologic Studies to complete the evaluation. As a faculty member of the Medical School's Department of Human Ecology and Community Health, Wynona has been personally instrumental in encouraging related prevention projects in the area through the Roots of Responsibility Program, which has involved volunteers in developing some 38 community interventions over the past 4 years.

William G. Hollister, M.D.

Bill Hollister is a board-certified psychiatrist who is also board certified in preventive medicine and public health. He entered mental health by designing and operating a combined Mental Health Education—Delinquency Prevention Project carried on in several Southern States. Joining NIMH in 1947, he did regional and State program development consultation for 7 years, then became NIMH's first National School Mental Health Consultant. He later became Chief of the Agency's Community Research and Services Branch before retiring in 1965 to join the staff of the Department of Psychiatry, University of North Carolina Medical School where he has been giving leadership in community psychiatry. He has devoted a major part of his time to setting up and training executive staff members for mental health centers.

Out of his previous experience and training in anthropology, education, group process, and public health he has long been interested in prevention and mental health education as integral parts of total patient care and comprehensive services to the community. He and his colleagues operated and studied a series of preventive programs reported in the pamphlet-book series "Experiences in Rural Mental Health." Under Bill's leadership the interdisciplinary Community Psychiatry staff at UNC regularly hold workshops and do consultations on prevention programming.

Donald C. Klein, Ph.D.

Don Klein, Project Director of the Pilot Conference on Primary Prevention, is a community psychologist. His interest in primary prevention dates back to 1953 when he became director of the Wellesley Human Relations Service, an experimental program in community health sparked by Dr. Erich Lindemann and a coalition of civic leaders, the Harvard School of Public Health, and other Harvard programs in social relations and medicine. A past President of the Division of Community Psychology of the American Psychological Association, he has been involved in the training of community mental health workers at Harvard, Boston University, and Johns Hopkins University. Interested in the impact of environmental factors on psychological well-being, he became involved with NTL Institute of Applied Behavioral Science (formerly the National Training Laboratories) in programs on small group dynamics, organizational change, and community development. His research in the area of primary prevention has focused on role transitions as emotional hazards (i.e., kindergarten entry and moving from one

Donald C. Klein (cont.)

nmunity to another) and testing a community development model for improving the delivery of human services to inner city neighborhoods. He is author of *Community Dynamics and Mental Health* and *Developing Human Services in New Communities.*

Walter L. Lauterbach, Ph.D.

Walter Lauterbach, who is based at the U.S. Public Health Service Regional Office in Philadelphia, has been the NIMH Regional Consultant in Mental Health Program Evaluation for the past 2 years. His work has brought him in contact with many community mental health centers that are involved in special projects in primary prevention, as well as other areas of program evaluation. He is currently a member of the NIMH National Task Force on Program Evaluation Standards.

With training in child psychology, Walter was previously a school psychologist, child guidance clinic director, and administrator of pupil personnel programs. Following postdoctoral training in mental health administration, he became interested in program evaluation and made a mid-career transition to mental health.

Vera S. Paster, Ph.D.

Vera Paster is a clinical psychologist who has spent her entire professional career in public service. Her work in primary prevention is based on extensive experience as school psychologist in the New York City schools, as the responsible person for school mental health services in the Bronx, and now as Assistant Director of New York City's school mental health agency. In the latter capacity she has worked with citizen groups, school personnel, and parents to develop primary prevention programs as well as programs of treatment and rehabilitation.

Her other major experience related to primary prevention involved helping to develop a community-controlled community mental health center. This center itself was an outgrowth of activities which can be viewed in terms of primary prevention. Once established, its programs placed considerable emphasis on the development of primary prevention projects (e.g., with tenant groups, young gang-aged males, and family groupings on a multi-family basis.)

Merrill F. Raber, M.S.W.

Merrill Raber is director of Growth Associates, a division of Prairie View, Inc., a community mental health program in Newton, Kansas. A native of Detroit, Michigan he received his baccalaureate degree from Goshen College in Indiana and his M.S.W. from the University of Southern California. He worked in the Pasadena Child Guidance Clinic and the Warner Guidance Center before coming to Prairie View in 1963. At Prairie View, Merrill has been a clinician, director of education and consultation, and director of community services before taking his present position.

For over a decade he has been involved in the application of group and organizational development methods to work with community groups in the interests of mental health. He has been associated with the NTL Institute for Applied Behavioral Science (formerly the National Training Laboratories); is involved with the OD Network, a national group of practitioners in the field of organizational change; and is a certified member of the International Association of Applied Social Scientists. He is a member of the National Association of Social Workers, the American Orthopsychiatric Association, and the Association of Humanistic Psychology.

Robert R. Santos, M.S.W.

Bob Santos is Director of the Primary Prevention Program of the Luzerne-Wyoming County Community Mental Health Center in Wilkes-Barre, Pa. In 1974 he assumed leadership of the NIMH-funded Part F project of the Center, which led to the development of a model for a preventive service delivery system that provides non-treatment services related to children via a wide range of projected delivery sites in the community. The program is now involved with the public school system, day care and health agencies, housing agencies, and churches. It is structured into three service areas: Infancy and Early Childhood, Childhood, and Adolescent/Young Adult.

Bob received his A.B. degree in social work from the University of Dayton in Ohio and his M.S.W. in community social work from Wayne State University, Detroit. Before becoming Director of the Primary Prevention Program, he spent 3 years developing and directing the Center's Consultation and Education Unit. He is a part-time instructor of graduate level social work courses at the School of Social Work, Marywood College, Scranton, serves on several community advisory boards, and is an officer of the Wilkes-Barre chapter of the N.A.S.W.

Myrna B. Shure, Ph.D.

Myrna Beth Shure is Associate Professor in the Department of Mental Health Sciences and head of child development studies at the Hahnemann Community Mental Health/Mental Retardation Center, Philadelphia, Pa. Since 1968 her primary responsibilities have focused on the design and execution of research and intervention in interpersonal problemsolving thinking skills of preschool and kindergarten children and on the effects of training teachers and mothers on the overt behavioral adjustment of these children. She is a licensed psychologist, Commonwealth of Pennsylvania.

Phyllis R. Silverman, Ph.D., M.S.Hyg.

Phyllis is married and mother of five children. She received the Ph.D. from the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University; the M.S. Hyg. from the Harvard School of Public Health; and the M.S.W. from the Smith College of Social Work. Over the past decade her work has primarily involved experiments with programs for primary prevention, reaching out to populations at risk with preventive resources in a context they could accept. This work led to the development of the widow-to-widow program. She has also been a member and worked with the LaLeche League of nursing mothers, helping new mothers to mother effectively. In the early 1960s she worked with black residents of Roxbury, Mass. to develop a tutorial program for school-aged children, using college volunteers.

As Director of the Brookline, Mass. Mental Health Association in 1960, she became aware of the educational role such associations and other groups could play in making mental health knowledge effectively available to people struggling with emotional and social problems. This experience helped focus her search for new models for making preventive resources more available to those who might need them. She has written extensively on the subject of mutual help and preventive intervention.

George Spivack, Ph.D.

George Spivack is Professor in the Department of Mental Health Sciences and Director of Research and Evaluation at the Hahnemann Community Mental Health/Mental Retardation Center, Philadelphia, Pa. For many years he has studied the overt behavior patterns of children. Currently he is investigating the use of kindergarten behaviors as predictors of subsequent adjustment and school success.

George Spivack (cont.)

He and Dr. Shure have worked together since 1968 in the area of interpersonal problemsolving thinking skills of young children. He is a Diplomate in clinical psychology and a licensed psychologist, Commonwealth of Pennsylvania.

John C. Wolfe, Ph.D.

John Wolfe is Executive Director, the National Council of Community Mental Health Centers, Inc., which has its headquarters in Washington, D.C. He has had an extensive background in the community mental health field, including work both in State hospitals and community-based programs. For 4 years he was Director of Program Development and Research of St. Anthony's Hospital CMHC in Rock Island, Illinois, and in 1969 he served as consultant to the Police-Community Relationship Program in Davenport, Iowa. In 1971 he moved to the National Institute of Alcoholism and Alcohol Abuse (NIAAA) where he was involved successively with special projects, treatment and rehabilitation programs, State and community assistance. From 1973 to 1975 he was Director of NIAAA's Division of Special Treatment and Rehabilitation Programs.

GUIDELINES FOR COMMUNITY MENTAL HEALTH CENTER TEAMS

For a little over 1 hour your CMHC team — supplemented by one or more other participants at the conference who are not associated with local mental health programs — has an opportunity to consider how best to apply what you have gained from the conference in your local setting.

Use the time, if you can, to develop the beginnings of a work plan that will help your mental health program get the most out of your participation in the conference.

Each team's work plan will be unique because it must fit each center's circumstances. However, we suggest that your team address itself to such questions as:

What changes, if any, in our current approaches to primary prevention should be explored?

Which individuals and groups within the center should be involved in the consideration of possible changes?

How should the desirability of such exploration be brought to the attention of center staff and board?

Are there other individuals or groups in the community who should be asked to participate? If so, when and how should they be involved?

What background information — from the conference or other sources — will be needed by board, staff, and others in order to take part in the explorations?

What specific next steps does the team need to take following its return from the conference? as individuals? as a team?

What part will each team member expect to take in the proposed exploration of possible changes in the center's current approaches to primary prevention?

What additional information will be needed — from the staff, board, and community — for the explorations to be fruitful?

What procedures might be proposed for use in conducting the explorations (e.g., a special task force of board and staff members; referral to the Program Committee of the Board; a 1-day workshop on primary prevention for interested citizens)?

SURVEY ON PRIMARY PREVENTION PROGRAMING

The information requested in this survey will be collated and fed back to respondents and participants at the beginning of the Pilot Conference on Primary Prevention for decisionmakers in community mental health, Philadelphia, Pa., April 2-4, 1976. The results will provide a basis for discussion of issues and concerns, help guide conference design, and provide one means for appraisal of the conference itself.

Data will be presented in summary fashion only. Individual centers' responses will not be identified and all information will be kept confidential.

Background Information

Name of Center: _____

Address: _____

Person Completing Questionnaire:

Name— _____

Title— _____

Discipline— _____

Total Population of Catchment Area:

Percentage of Ethnic Groups in the Population:

_____ Black
_____ White
_____ Spanish speaking
_____ Native American
_____ Asian
_____ Other
100% TOTAL

Is the Area Primarily Urban?___ Rural?___ Both Urban and Rural?___

Yes	No	
___	___	Is the center a consortium or grouping of separate agencies and programs?
___	___	Does the center have separately located outreach facilities?
___	___	Has the center formulated a specific written policy about primary prevention?
___	___	Are you in the process of developing a policy about primary prevention?
___	___	Is the center a federally funded comprehensive community mental health center?
___	___	Does the center serve a poverty designated area?

How Many Years Has the Center Been in Operation?_____

DEFINITION OF PRIMARY PREVENTION FOR PURPOSES OF THE SURVEY

Primary Prevention has been defined in various ways within the community mental health field. For the purposes of the pilot conference and this survey, it is being considered as only one of several possible functions under the heading of Consultation and Education. When responding to the following questions, please use this definition of Primary Prevention as your guide:

> PRIMARY PREVENTION PERTAINS TO THE REDUCTION OF THE INCIDENCE (i.e., rate of occurrence of new cases) OF UNDESIRABLE BEHAVIORS OR CONDITIONS AMONG SPECIFIC SUBGROUPS IN A COMMUNITY'S POPULATION. IT INVOLVES INTERVENTION PRIOR TO THE OCCURRENCE OF TROUBLED STATES.

Primary Prevention: Examples of programs which fall under the heading of Primary Prevention according to this definition:

1. Self-help support groups with newly widowed persons to help them cope with the new life stress and reduce the incidence of severe depressions among them.
2. Coordinated educational and support services for mothers of newborn infants to reduce anxiety and depression among mothers and increase the extent to which mothers perceive their infants as normal and healthy.
3. Psychological education of school-age children in order to reduce the rate of occurrence of severe behavior disorders.

Secondary Prevention: Examples of programs which are generally considered to be Secondary Prevention and, therefore, do *not* fall under the heading of Primary Prevention according to this definition:

1. *Crisis group therapy* with moderately depressed widows to help restore their pre-bereavement level of social and emotional functioning
2. *Early identification and treatment* of postpartum depression
3. *Case consultation* to public school personnel to help them cope with problem children and make more appropriate referral of pupils for psychodiagnostic and treatment services

1a. Please make a rough *estimate* percent of overall staff time in an average week now devoted to Primary Prevention activity in your center: ____%; to Secondary Prevention: ____%.

1b. Ideally, what percent of staff time would you like to be able to devote to Primary prevention programing: ____%.

NOTE: If your answer to 1a is zero (0) percent, move directly to questions No. 7, 8, and 9. Otherwise, continue with question No. 2.

2. Please check below the institutions and groups with whom you are in contact on a regular basis as part of the center's Primary Prevention programing:

a. __ Public schools
b. __ Nursery schools or day care programs
c. __ Law enforcement agencies
d. __ Employment service
e. __ Clergy
f. __ Physicians
g. __ Mental health association
h. __ Other mental health facilities
i. __ Public health department or other health agencies
j. __ Social service agencies
k. __ Community planning agency
l. __ Alcoholics Anonymous or other self-help groups
m. __ Youth serving organizations
n. __ Service clubs
o. __ Family planning service
p. __ Others (please list):

_____
_____
_____
_____
_____

3. Please check each group for which you have a specific program:

a. __ Engaged couples
b. __ Parents-to-be
c. __ New parents
d. __ Preschool children
e. __ Children and families at school entry
f. __ Elementary school children

continued

g. ___ Secondary school children
h. ___ Predelinquents
i. ___ Single parents
j. ___ Chronically unemployed
k. ___ Newly unemployed persons
l. ___ Newcomers to the community
m. ___ Families with a chronically ill or disabled member
n. ___ Families with severely handicapped children
o. ___ Families with a hospitalized member
p. ___ Pre- or post-retirees
q. ___ Poor people
r. ___ Disaster victims
s. ___ Disadvantaged and oppressed ethnic groups
t. ___ Migrants
u. ___ Adult singles
v. ___ Bereaved persons
w. ___ Others (please list):

_____

_____

_____

_____

4a. Please respond to each of the following questions about how Primary Prevention activities are *managed* within your center:

	Yes	No
(1) Is Primary Prevention a separate designated area of responsibility?	___	___
(2) Is there a Primary Prevention team in your center?	___	___
(3) Is there a designated committee of your center's board responsible for Primary Prevention policy formulation?	___	___
(4) Is one staff member responsible for coordination of Primary Prevention work?	___	___
(5) Is most Primary Prevention work carried out as a secondary activity by staff members with major responsibilities in other center programs?	___	___

4b. If there is a single staff person responsible for Primary Prevention:

(1) Discipline: _____

(2) Location in the center's administrative organization:
(a) ___ Center Director's office
(b) ___ Office of the Consultation and Education coordinator
(c) ___ Within another program area (e.g., outpatient services)
(d) ___ Within the office of one of the professional disciplines
(e) ___ Other (please specify): _____

_____

5. Staffing Pattern for Primary Prevention Programing: First, indicate on the *left* the number of full-time and part-time staff in each category. Second, indicate on the *right* for each kind of staff the number of persons devoting full-, part-, or no time using the percent categories provided.

Total Staff			Number of Staff Devoting Full-, Part-, or No Time to Primary Prevention				
				Part-time			
Full-time	Part-time	Type of Staff	Full-time	75%+	25% to 75%	-25%	No time
___	___	Psychiatrists	___	___	___	___	___
___	___	Other physicians	___	___	___	___	___
___	___	Psychologists	___	___	___	___	___
___	___	Social workers	___	___	___	___	___
___	___	Health educators	___	___	___	___	___
___	___	Nurses	___	___	___	___	___
___	___	Other mental health workers	___	___	___	___	___
___	___	Volunteers	___	___	___	___	___
___	___	Nonmental health professionals	___	___	___	___	___
___	___	Paid nonprofessionals	___	___	___	___	___
___	___	Other (list): ___	___	___	___	___	___
___	___	___	___	___	___	___	___
___	___	TOTAL					

6. How is Primary Prevention programing funded within your agency?

A. *Nature of Funding* (Please check all that apply)

(1)__ General operating budget of the Center
(2)__ Special grants
(3)__ Fees for service
(4)__ Contracts with client groups and agencies
(5)__ Donations
(6)__ Revenue sharing
(7)__ Other (please describe): ___

B. *Sources of Funding* (Please check all that apply)

(1) __ Private funds and foundations

(2) __ Federal agencies:

__ (a) National Institute of Mental Health

__ (b) Office of Child Development

__ (c) U.S. Office of Education

__ (d) Law Enforcement Assistance Administration

__ (e) National Institute on Drug Abuse

__ (f) National Institute on Alcohol Abuse and Alcoholism

__ (g) Social and Rehabilitation Service

__ (h) Other (please list):

(3) __ State Agencies:

__ (a) Health

__ (b) Mental health

__ (c) Other (please list): _____

(4) __ Community groups (e.g., business, service clubs, religious groups)

(5) __ Local government

(6) __ Other (please describe): _____

_____

7. Please indicate your assessment of the influence of each of the following factors in reducing or increasing the amount of effort your center devotes to Primary Prevention programing.

Factors	Influence on the Amount of Effort				
	Reduces effort greatly	Reduces effort	Neither reduces nor increases	Increases effort	Increases effort greatly
a. Number of staff with needed skills	-2	-1	0	+1	+2
b. Importance of Primary Prevention as a mental health function	-2	-1	0	+1	+2
c. Level of staff interest in Primary Prevention	-2	-1	0	+1	+2
d. Availability of methods to do the job	-2	-1	0	+1	+2
e. Amount of effort required for direct service demands	-2	-1	0	+1	+2
f. Level of priority given to Primary Prevention by board members	-2	-1	0	+1	+2
g. Level of community support for Primary Prevention	-2	-1	0	+1	+2
h. Policy reflected in State guidelines	-2	-1	0	+1	+2
i. Policy reflected in Federal guidelines	-2	-1	0	+1	+2
j. Number of at-risk groups for whom programs are needed	-2	-1	0	+1	+2
k. Available funds for Primary Prevention	-2	-1	0	+1	+2
l. Center's prior experience with Primary Prevention programing	-2	-1	0	+1	+2
m. Ability to evaluate program effectiveness	-2	-1	0	+1	+2

8. List below the major frustrations you either anticipate or have experienced in delivering Primary Prevention programs (be as specific as possible):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

9. Please indicate the importance of each of the following needs for your center in the area of Primary Prevention:

Area of Need	Importance		
	Not Important	Somewhat Important	Very Important
a. Techniques for motivating community groups to work on Primary Prevention projects	1	2	3
b. Techniques for assessing community needs in the area of Primary Prevention	1	2	3
c. Staff development training to help Center staff members learn how to plan and conduct Primary Prevention work	1	2	3
d. Help in developing effective Primary Prevention programs for designated "high-risk" groups	1	2	3
e. Improved ways of organizing and managing Primary Prevention activities	1	2	3
f. Techniques for evaluating Primary Prevention efforts	1	2	3
g. A mandate from community groups to carry on Primary Prevention work	1	2	3
h. A mandate from the center board to engage in Primary Prevention work	1	2	3
i. Help in securing adequate funds for doing the Primary Prevention that is needed	1	2	3
j. Others (please list): _____			

If there is anything that we have not covered that you feel should be included, please use the following space and an extra sheet if needed. And thank you for your assistance.

MAIL SURVEY BEFORE FEBRUARY 20, 1976 to:

Donald Klein, Ph.D.
Pilot Conference
NAMH
1800 North Kent St.
Arlington, Va. 22209

GUIDELINES FOR CONFERENCE WORK GROUPS

TASK: OUTLINE PLANS FOR A PRIMARY PREVENTION PROGRAM ON BEHALF OF THE WORK GROUP'S SPECIFIC TARGET POPULATION

SUGGESTIONS FOR HOW TO APPROACH THE TASK:

1. Feel free to generate assumptions about the target population. Given the short time available, generate assumptions that will help the work group complete its task.
2. Be brief and stay within the limits of the two-page work sheet.
3. Transfer your working plan to the ditto masters after plans have been completed. Print legibly so that others can read your outline.
4. While staying within feasible limits, stretch your imagination and be as innovative as you can.
5. Try to follow the work sheet item by item. It is intended to provide a helpful guide to your work.
6. Remember that at 4 p.m. there will be concurrent workshops on Funding, Community Involvement, Evaluation, and Management of Primary Prevention Programs. Divide up so that someone from the work group attends each workshop.

SUGGESTIONS FOR HOW TO WORK AS A TEAM:

1. Check your resources. Begin by finding out:
   a. Who is in the group? What experiences and skills do they bring?
   b. What hopes and frustrations do work group members have about the target population?
   c. What bright ideas and enthusiasms do members have about programs for this target population?
2. In the early stages, concentrate on getting everyone's ideas on the table. Try to avoid taking up time by debating individual suggestions until after all ideas have had an airing and there has been time to analyze both the problem and the possibilities.

3. If you encounter problems about the task itself or in your group process, feel free to ask for help from your staff consultant.

We hope the work group experience proves enjoyable, productive, and useful for your understanding of Primary Prevention programing.

WORK SHEETS FOR CONFERENCE WORK GROUPS

TARGET POPULATION ("At-Risk" Group): _____

1. *Describe the target population* (e.g., age and sex distribution; socioeconomic characteristics):

2. *Identify major stress(es) affecting the target population:*

3. *What problems or major disablements within the target population do you wish to reduce or eliminate?*

4. *Establish one or more provisional working objectives* (include, if possible the proportion of the target population to be reached and stated time periods for achieving objectives):

5. Identify programs that might produce:

A. Stress Management:	C. Stress Resistance Building:
B. Stress Avoidance:	D. Stress Reaction Management:

6. In view of the programs outlined in #5, go back to the Provisional Working Objectives (#4). Should any be eliminated or altered? Which of them seems most important? most practical? If needed, *formulate the new working objective(s)*:

7. *Select one or more institutions or groups* in the community that must be involved in working toward the objectives: Which person(s) need to be involved?

8. *What steps will be taken to secure the interest and cooperation of the community groups or institutions?*

9. Taking your objectives and approaches into account, *outline an achievable program* to be carried out with the community institution(s) or group(s):

10. *How will the program be evaluated?*

A. To identify needed changes while program is underway:

B. To determine the extent to which objectives have been met:

11. What *level of funding* will be needed? What *sources of funding* should be approached?

PRECONFERENCE EVALUATION

Introduction

One goal of the Pilot Conference is to determine whether and how such conferences should be held elsewhere. Both at the beginning and close of the pilot, participants are being asked to help out by completing evaluation forms. On the last day further information also will be gathered by brief group interviews.

We need your help and appreciate your cooperation in responding to this evaluation form and the one you'll be given at the close of the conference.

Please check the item from each list which best identifies you:

AGENCY

___ Local community mental health center or program
___ State government
___ NIMH
___ Local association for mental health
___ State association for mental health
___ National Association for Mental Health
___ Other

POSITION

___ Board member
___ Administrator
___ C & E Director
___ Agency staff member
___ Volunteer
___ Other

To help us make pre- and post-Conference comparisons, please write the *last four* (4) *digits of your phone number* in the right-hand lower corner of this page. Or if you prefer, use your name.

Last 4 Digits

I. Please list below the expectations you have of this conference. That is, what specifically do you want to take away from this experience?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

II. How important to you is each of the following conference objectives?

OBJECTIVES With reference to Primary Prevention, to increase	Not relevant (0)	Slight importance (1)	Fairly important (2)	Very important (3)	Extremely important (4)
1. familiarity with program strategies	0	1	2	3	4
2. understanding of approaches to evaluation	0	1	2	3	4
3. related activities at participating mental health centers	0	1	2	3	4
4. ability to identify and intervene with "at risk" target groups	0	1	2	3	4
5. ability to set priorities among possible target groups	0	1	2	3	4

III. What degree of importance do you attach to each of the activities listed below for a community mental program? Use the following scale:

1 = Not important. Should not be provided.
2 = Of little importance. Provide only if all other activities are provided.
3 = Fairly important. Include if other more important activities are provided.
4 = Very important. Include among the highest priority activities.
5 = Essential. By all means include in any Center's activities.

Possibly activity of a community mental health program	Importance 1 Not important	2	3 Fairly important	4	5 Essential
1. Psychological education of young children to help prevent behavior problems	1	2	3	4	5
2. Group therapy for adult outpatients	1	2	3	4	5
3. Consultation to teachers to help them deal with problem children	1	2	3	4	5
4. Sheltered workshop for ex-mental hospital patients	1	2	3	4	5
5. Marriage counseling	1	2	3	4	5
6. Diagnosis and treatment of children	1	2	3	4	5
7. Educational and support services for mothers of newborn infants	1	2	3	4	5
8. 24-hour emergency psychiatric service	1	2	3	4	5
9. Short-term inpatient service for adults with acute emotional problems	1	2	3	4	5
10. Mutual help support groups for newly widowed persons	1	2	3	4	5

IV. If you are a staff or board member of a mental health center, please make a rough estimate of overall staff time in an average week now devoted to Primary Prevention activity in your center:

_____ None
_____ Less than 5%
_____ 5 to 9%
_____ 10 to 19%
_____ 20% or more

If you are *not* a staff or board member of a mental health center, please make a rough estimate of the average amount of overall staff time now devoted to Primary Prevention activity in the average CMHC in this general region:

_____ None
_____ Less than 5%
_____ 5 to 9%
_____ 10 to 19%
_____ 20% or more

V. Ideally, what percent of staff time would you like to have devoted to Primary Prevention programing (in your center if you're a staff or board member; in the average center if not). Percent: _____

POSTCONFERENCE EVALUATION

Introduction

As you know, an important goal of the pilot conference is to determine whether and how such conferences should be held elsewhere. If you were present from the beginning, you were asked to fill out a preconference evaluation. Some of the items from that form are repeated in the postconference evaluation to determine what changes, if any, have taken place in participants' thinking. There are also several items asking about your reactions to the conference itself.

We appreciate your cooperation in responding to the evaluations. Your responses will definitely be considered in the planning which will follow this pilot venture.

Please check the item from each list which best identifies you:

AGENCY

___ Local community mental health center or program
___ State government
___ NIMH
___ Local association for mental health
___ State association for mental health
___ National Association for Mental Health
___ Other

POSITION

___ Board member
___ Administrator
___ C & E Director
___ Agency staff member
___ Volunteer
___ Other

To help us make pre- and postconference comparisons, please be sure to write the last four (4) digits of your phone number in the right-hand lower corner of this page (or your name if you used that instead on the preconference form).

Last 4 digits

I. Thinking back to where you were on Friday when the conference began vs. where you are now, what degree of change have you experienced in each of the following areas:

	-5 Greatly decreased	-3	0 Neither decreased nor increased	+3	+5 Greatly increased
1. Familiarity with program strategies in primary prevention	-5	-3	0	+3	+5
2. Understanding of approaches to evaluation of primary prevention programs	-5	-3	0	+3	+5
3. Interest in having primary prevention programing increased at our center (or centers generally)	-5	-3	0	+3	+5
4. Ability to identify and intervene with "at-risk" target groups	-5	-3	0	+3	+5
5. Ability to set priorities among possible target groups	-5	-3	0	+3	+5
6. Commitment to increased primary prevention even if more funds are not available	-5	-3	0	+3	+5

II. If you are a staff or board member of a mental health center, please make a rough estimate of overall staff time in an average week now devoted to Primary Prevention activity in your center:

_____ None
_____ Less than 5%
_____ 5 to 9%
_____ 10 to 19%
_____ 20% or more

If you are *not* a staff or board member of a mental health center, please make a rough estimate of the average amount of overall staff time now devoted to Primary Prevention activity in the average CMHC in this general region:

_____ None
_____ Less than 5%
_____ 5 to 9%
_____ 10 to 19%
_____ 20% or more

III. Ideally, what percent of staff time would you like to have devoted to Primary Prevention programing (in your center if you're a staff or board member; in the average center if not). Percent: _____

IV. How important is it for a community mental health program to provide each of the activities listed below? Use the following scale:

1 = Not important. Should not be provided.
2 = Of little importance. Provide only if all other activities are provided.
3 = Fairly important. Include if other more important activities are provided.
4 = Very important. Include among the highest priority activities.
5 = Essential. Must be included in the center's basic activities.

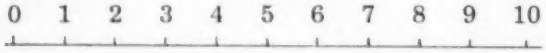
Possible activity of a community mental health program	Importance				
	1 Not important	2	3 Fairly important	4	5 Essential
1. Psychological education of of young children to help prevent behavior problems	1	2	3	4	5
2. Group therapy for adult outpatients	1	2	3	4	5
3. Consultation to teachers to help them deal with problem children	1	2	3	4	5
4. Sheltered workshop for ex-mental hospital patients	1	2	3	4	5
5. Marriage counseling	1	2	3	4	5
6. Diagnosis and treatment of children	1	2	3	4	5
7. Educational and support services for mothers of newborn infants	1	2	3	4	5
8. 24-hour emergency psychiatric service	1	2	3	4	5
9. Short-term inpatient service for adults with acute emotional problems	1	2	3	4	5
10. Mutual help support groups for newly widowed persons	1	2	3	4	5

V. If a registration fee had been required for this conference (not including room and board):

A. In light of your experience, what fee would you personally have been willing to pay? _____

B. What fee would you recommend your agency should have been willing to pay in terms of the value of the conference to local community mental health centers? _____

VI. Think of the worst conference you ever attended and rate it zero (0) on the following scale. Think of the best conference you ever attended and rate it ten (10) on the scale. Then consider how you would rate this conference. Please put an X on the scale at the point which relates it to the worst and best conferences you've attended.



Worst Conference — Best Conference

VII. In terms of its value to you and your efforts in community mental health, please indicate how helpful each of the components of the pilot conference was for you:

COMPONENTS OF THE CONFERENCE	Not helpful 1	Somewhat helpful 2	Helpful 3	Very helpful 4
FRIDAY				
A. Presentation and discussion of data from Preconference survey	1	2	3	4
B. Presentation: "An Overview of Primary Prevention Programing" (Goldston)	1	2	3	4
C. Concurrent Workshops I: Primary Prevention for Specific Target Groups (check the one you attended)	1	2	3	4
__ 1. Programs for New Born Infants (Broussard)				
__ 2. Affective Education with School Age Children (Hartley)				
__ 3. Mutual Help Groups for Widows (Silverman)				
__ 4. Cognitive Education of Pre-Schoolers (Spivack and Shure)				
SATURDAY				
D. Concurrent Workshops II: Agency Strategies for Primary Prevention (check the one you attended)	1	2	3	4
__ 1. Epidemiological Approach (Bloom)				
__ 2. Programs With Disadvantaged Community Groups (Paster)				

COMPONENTS OF THE CONFERENCE	Not helpful 1	Somewhat helpful 2	Helpful 3	Very helpful 4
SATURDAY—Continued				
3. Cultivating Personal and Leadership Skills in the Community (Raber)				
4. Programs With Major Community Institutions (Santos)				
E. Presentation on "Strategies for Primary Prevention" (Hollister)	1	2	3	4
F. Mini-workshops on Strategies	1	2	3	4
G. Presentation: "Evaluating Achievable Objectives for Primary Prevention" (Bloom)	1	2	3	4
H. Work Groups: work on outlining plans for "at risk" target group	1	2	3	4
I. Concurrent Workshops III: Aspects of Prevention (check the one you attended)				
___ 1. Funding (Baxter)				
___ 2. Involvement of the Community (Raber)				
___ 3. Evaluation (Lauterbach)				
___ 4. Management (Hollister)				
SUNDAY				
J. Project Response Panel reviewing and discussing sample work group reports	1	2	3	4
K. CMHC teams: developing work plans for own localities	1	2	3	4
L. Clinic Clusters: CMHCs within geographic areas consult on each other's plans	1	2	3	4
M. Final General Session With Resource Panel	1	2	3	4

VIII. FOR THE PLANNING OF FUTURE CONFERENCES ON PRIMARY PREVENTION: WHAT IMPROVEMENTS WOULD YOU SUGGEST AND WHAT WOULD YOU TRY TO KEEP THE SAME WITH RESPECT TO EACH OF THE FOLLOWING AREAS:

	SUGGESTED IMPROVEMENTS	ELEMENTS TO KEEP THE SAME
A. Recruitment and selection of participants		
B. Preconference materials		
C. Conference location and facilities		
D. Logistical support (audiovisuals, resource room, etc.)		
E. Conference staffing		
F. Conference content		
G. Conference design and procedures		
H. Conference evaluation		
I. Other		

POSTCONFERENCE EVALUATION

Goal Attainment Survey

INTRODUCTION: The following list of goals and expectations was taken from participants' hopes for the conference expressed in the preconference questionnaire. Please respond to each item. If an item was not one of your objectives when you arrived here and is still not an objective for you, please check the space marked "Not a relevant goal for me." If the item was an objective for you when you arrived or became one during the conference, indicate whether for you it was "not met," "met," or "more than met." DON'T FORGET TO LIST THE LAST 4 DIGITS OF YOUR PHONE NO. (OR YOUR NAME IF YOU USED THAT ON THE PRECONFERENCE QUESTIONNAIRE) IN THE LOWER RIGHT CORNER OF THIS PAGE.

GOAL OR EXPECTATION	NOT A RELEVANT GOAL FOR ME	RELEVANT GOAL THAT WAS: Not met	Met	More than met
1. Learn about new program ideas	____	____	____	____
2. Reevaluate my own ideas	____	____	____	____
3. Become clear about what is meant by "primary prevention"	____	____	____	____
4. Learn as much as possible about all areas of primary prevention	____	____	____	____
5. Examine effectiveness of different models for prevention	____	____	____	____
6. Learn about techniques and strategies	____	____	____	____
7. Learn how to identify "high-risk" target groups	____	____	____	____
8. Learn more about evaluating preventive programs	____	____	____	____
9. Learn how to demonstrate that primary prevention pays off	____	____	____	____
10. Learn how to get prevention programs started	____	____	____	____

LAST 4 DIGITS OF MY PHONE NO.

GOAL OR EXPECTATION	NOT A RELEVANT GOAL FOR ME	RELEVANT GOAL THAT WAS: Not met	Met	More than met
11. Explore interventions to use with specific groups (e.g., clergy, police, schools)	____	____	____	____
12. Learn ways to stimulate self-support groups	____	____	____	____
13. Explore strategies for developing preventive programs	____	____	____	____
14. Learn about funding sources	____	____	____	____
15. Learn to plan preventive programs for an entire catchment	____	____	____	____
16. Explore ways to manage primary prevention programs	____	____	____	____
17. Be better able to involve community groups in programs	____	____	____	____
18. Learn ways to set up preventive programs in rural areas	____	____	____	____
19. Learn how to set realistic goals for preventive efforts	____	____	____	____
20. Get *practical* ideas that match how people really respond	____	____	____	____
21. To learn about doable programs with limited resources	____	____	____	____
22. Find ways to reduce competition between C & E and direct services	____	____	____	____
23. Learn how to interest clinical staff in primary prevention	____	____	____	____
24. Develop strategies for "selling" prevention to my Director	____	____	____	____
25. Meet others in the field	____	____	____	____
26. Get information about others' efforts	____	____	____	____
27. Develop stimulating contacts with nearby CMHC prevention programs	____	____	____	____
28. Exchange ideas with other communities	____	____	____	____
29. Learn about sources of ongoing future information	____	____	____	____
30. Get help in developing our prevention programs	____	____	____	____
31. Get to know resource people for future reference	____	____	____	____
32. Renew my enthusiasm for primary preventive work	____	____	____	____
33. Do some planning with members of my CMHC team here	____	____	____	____
34. Develop specific plans for prevention in our community	____	____	____	____
35. Get an answer to *the* question: "Is it possible to do prevention at all?"	____	____	____	____

POSTCONFERENCE EVALUATION

Group Interview

For use with cluster groups on Sunday afternoon, following completion of individual questionnaires.

1. HOW DO YOU FEEL ABOUT THE CONFERENCE?

2. WHAT HELPED MAKE IT A USEFUL EXPERIENCE FOR YOU?

3. WHAT HINDERED ITS USEFULNESS TO YOU?

4. INQUIRE SPECIFICALLY ABOUT ANY OF THE FOLLOWING AREAS NOT COVERED IN PREVIOUS DISCUSSION (If you had the job of putting on another such conference, what would you be keeping in mind about. . . .)

   A. Participant selection and mix

   B. Preconference materials

   C. Location and facilities

   D. Staffing

   E. Content

   F. Design

   G. Evaluation

MEMORANDUM

April 22, 1976

TO: Participants, Pilot Conference on Primary Prevention

FROM: Don Klein, Project Director

SUBJECT: POSTCONFERENCE FOLLOWUP EVALUATION

I earnestly solicit your help in assessing the impact of the Pilot Conference now that a few weeks have gone by since we shared the experience. I will very much value your thoughtful comments about the nature and extent of influence, if any, the Conference may be having on you and the mental health activities in which you are involved.

The enclosed questions are intended to give you some guidelines for your reply. I hope you will follow them only if you find them helpful. I really want and need your own ideas and reflections about the experience and what it has — and has not — meant for you, as well as your thoughts about what, if anything, it may mean in the months to come.

I ask you, please, to respond to this request. We are just beginning to work on the final report of the project, which must address itself to the question of whether and how similar conferences should be held elsewhere in the country. So I urge you to set some time aside today or tomorrow to share your comments with me.

You'll be interested to know that Steve Goldston and I have set ourselves the task of working on a Conference Proceedings, which will be published separately from the Final Report. Basically the Proceedings will pull together the presentations, workshop summaries, and work group reports so that others who were not at the conference can have them.

Please be totally frank in your comments. We will learn from your negative criticisms, uncertainties, and skepticism as well as from your enthusiasms and reports of progress.

Thank you very much, in advance, for your cooperation and support.

Enclosure

POSTCONFERENCE FOLLOWUP EVALUATION

IMPORTANT: So that your comments can be taken into account in preparation of the Final Report and Conference Proceedings, *please respond by April 30* at the latest, if possible in the next day or two.

NAME: (Optional) _____

LAST 4 DIGITS OF PHONE NO. (If you used this means of identifying questionnaires at the conference itself):

CHECK THOSE THAT APPLY:

___ Board member	___ CMHC	___ Local
___ Staff member	___ NAMH	___ State
___ Other	___ Other organization	___ National

I. WHAT EFFECT, IF ANY, HAS THE PILOT CONFERENCE EXPERIENCE HAD ON YOU SO FAR, BOTH PERSONALLY AND IN TERMS OF YOUR ROLE (that is, as board member, staff member, associate member, or other role you play?)

II. WHAT HAS THE EXPERIENCE MEANT SO FAR IN TERMS OF MENTAL HEALTH ACTIVITIES OR PROGRAMS IN WHICH YOU ARE INVOLVED? (Has anything happened that you would trace to the conference? What steps, if any, have been taken? What plans have been made? What actions or planning do you expect to take place and when?)

III. WHAT BARRIERS, IF ANY, STAND IN THE WAY OF MAKING USE OF THE CONFERENCE IN YOUR MENTAL HEALTH ACTIVITIES? (Do you expect them to persist?)

(Please use reverse side if needed)

U.S. GOVERNMENT PRINTING OFFICE : 1977 O - 244-150